Client Outcomes Assessments and Service Model Implementation for Vision Australia

An Interactive Qualifying Project
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1. outcomes assessment
2. service model
3. disability

Abstract

Vision Australia, a provider of services to the blind and vision impaired in Australia, is three years removed from the merger which resulted in its conception. A new client service model has been developed by the organization in an effort to achieve continuous improvement in client outcomes. The goal of this project was to make suggestions for evaluating the implementation of the new service model in addition to developing a framework for the evaluation of client outcomes. Both old and new service models were analyzed, interviews were conducted with personnel from Vision Australia, and archival data from the pre-merger organizations were researched to discern the differences between the pre-merger organizations, understand the current methods of qualitative outcomes assessment, and conclude on suggestions for the amalgamation of the pre-merger service models. This project identified a list of indicators for measuring the implementation of the new service model and created a framework for assessing client outcomes.

Executive Summary

Vision impairment has a great impact on the daily lives of Australians. Within the next twenty years, the number of Australians with a vision impairment is expected to increase from 480,000 to nearly 800,000 people (Unightforsite, 2007). The leading provider of services to the blind and visually impaired in Australia is Vision Australia, an organization that resulted from the merger of three major visual disability organizations in 2004 (the Royal Blind Society, the Royal Victorian Institute for the Blind, and the Vision Australia Foundation).

Although the merger occurred nearly three years ago, the pre-merger business units of Vision Australia are still functioning under different client service models. Vision Australia has recently developed a unified client service model; developing suggestions for evaluating the implementation of the new model was one of the key deliverables of this project. In addition, a new shift towards the quantification of client outcomes has accompanied the service model of Vision Australia. The second deliverable for this project was, then, to develop an outcomes assessment framework by which Vision Australia could measure the impact of its services on the lives of clients.

Preliminary background information was sought in an effort to understand the context of the situation and the history of the organization. General information regarding the merger and history of Vision Australia was acquired in addition to statistics on the vision impaired in Australia. In addition, the new service model of Vision Australia was examined to understand exactly what was to be implemented.

Several international approaches to outcomes assessment were reviewed, and literature regarding the definitions of client outcomes and the necessity for outcomes assessment was analyzed. These outcomes assessment measures were classified into two categories, quality of life and task-based. The roles of typical Vision Australia employees were also studied to make early inferences as to which outcomes assessment techniques would be useful.

Throughout the course of the project, information was gathered through interviews, focus groups, and further literature research. Interviews were conducted with service staff, local management, and senior management to determine how outcomes were perceived, how the different service centers were operating, and suggestions for the implementation of the new service model. Valuable information on the differences that must be overcome in the amalgamation into the new client service model was gathered through both interviews and

examining the archival service models of the pre-merger organizations. These differences included intake procedures, record keeping, and evaluation of client outcomes.

Client service model framework documents were collected from each of the pre-merger organizations as well as from Vision Australia. As the main objective for this part of the project concerned evaluating the extent of the new client service model implementation, it was necessary to understand what aspects were retained from each of the three previous organizations. It was also important to determine the main focuses of the new VA model document that were necessary before effective implementation assessments could be recommended.

Through interviews with management and as well as thorough review of the service model documents, it was established that client intake, records and data collection, and communication between the organization and the client were the main focuses of the new service model. This does not mean other important aspects were not found such as training and underlying service themes; these aspects of the service model document are just secondary to the three main concepts upon which recommendations were based.

Client intake, or the process by which a new client is integrated into the VA service system, was a primary goal of the management. The pre-merger organizations all had different methods for client intake ranging from formal assessments conducted in person to phone conversations. The VA model calls for the establishment of the National Contact Center (NCC). This center will serve as a common entry point for all initial calls to the organization. The NCC is to be responsible for the initial client records as well. Basic information about client needs and goals will be electronically documented and then forwarded to the appropriate local service center.

Vision Australia should periodically evaluate the extent to which information is being recorded in the client electronic file. The NCC should be responsible for assessing the extent that client files are being forwarded to the most appropriate local office. Finally, information should be distributed to the staff of VA concerning the purpose of the NCC. Also included should be what the organization expects a local service center to do once a new client file has been received from the NCC. Providing this information will allow all staff to understand what is expected and make it easier for all service centers to follow the same procedures.

The second important theme of the service model document is record keeping and data collection. Based on the pre-merger affiliation, service centers either kept the client files electronically, paper documented, or a combination of the two. VA would like the organization to use the Client Management System (CMS) electronic program for all clients

in all service provision areas. To evaluate the implementation of this requirement, the regional managers should review the process and assess all closed cases with the specialists at team meetings or individual conferences. Any problems should be brought to the attention of the managers, who will compile the information and report to senior management.

The third theme of the service model document was communication and centered on the concept of a key contact. A key contact is the client's liaison to the organization that refers clients to products and services and through which a personal rapport can be established. To assess the implementation of key contacts, the regional managers should monitor the number of clients assigned to each staff member at the monthly team meetings. These reports could then be forwarded on to the senior management when necessary for the collection of relevant data.

A framework for assessing client outcomes was also developed so that Vision Australia could quantify client outcomes in both task based and quality of life forums. The framework included the types of available outcomes assessments, administration of these assessments, and a cycle for continuous organization improvement through internal analysis of aggregate outcomes data. The entire outcomes assessment framework can be broken down into three tiers: intake, service provision and outcomes assessment, and continuous improvement.

Focus groups with current clients were conducted with the purpose of developing a picture of the clients' perspective of outcomes in addition to understanding the outcomes assessment techniques that best suited them. These ideas were coupled with suggestions from management and information from the literature on outcomes assessment to develop a framework for evaluating client outcomes. This framework includes a common language to describe client outcomes, proven outcomes assessment tools, suggestions on the administration of outcomes assessments, and opportunities for analyzing outcomes data that are conducive to continuous improvement. The suggestions for the assessment of client outcomes can be summarized in a structured iterative process as shown in Figure 1.

The first step is to conduct a pre-assessment of the client to understand what service provision is necessary. At this time, the client establishes goals with the key contact. It is essential that the client's input is considered when determining the exact service provisions and the goals that will be accomplished through the services. Communication is an essential component of ensuring causation of positive outcomes and client participation in subsequent outcomes assessments.

During service provision outcomes can be assessed at the discretion of the service coordinator and service provider, however an outcomes assessment should be conducted at the assumed conclusion of the client's services. If the goals of the client have changed, the client would re-enter the service provision cycle with a re-assessment of goals and appropriate service provision. This cycle would continue until outcomes that are acceptable to the client are achieved.
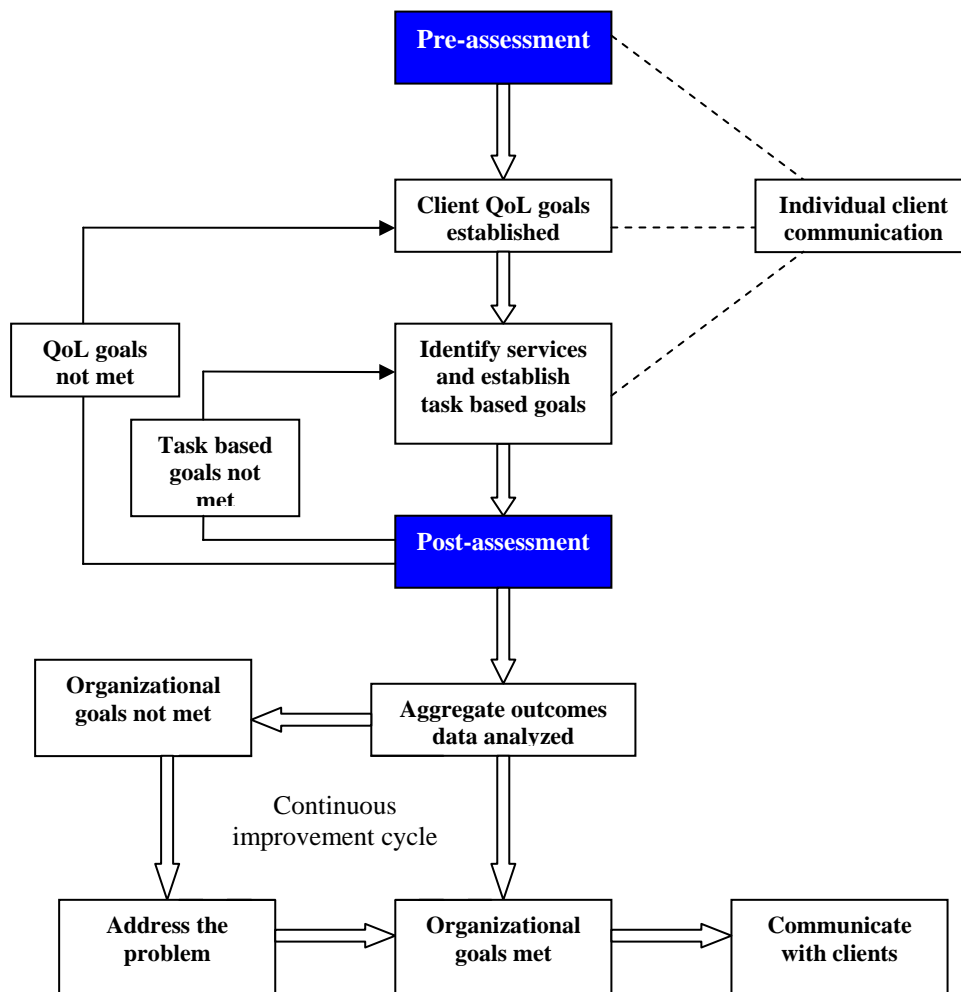
Figure 1- Recommended Outcomes Framework

On an organizational level, action teams (interdisciplinary groups of service personnel) would assess the aggregate client outcomes information in terms of the organizational goals set in early 2007 by teams of local and senior management. If the outcomes data are determined to insufficiently meet the goals of the organizational, these interdisciplinary service provider teams can resolve the issues and implement their own decisions.

A theme of the new service model that is essential to quality outcomes data is communication with the client. Allowing maximum client input on all areas surrounding

service provision and outcomes assessment allows for greater causation of positive client outcomes. The organization needs to communicate to the clients the ways in which the organization changes based on the outcomes feedback that client provide. The aforementioned outcomes assessment suggestions serve as a framework that Vision Australia can implement in an effort to optimize client outcomes and organizational efficiency.

The suggestions for evaluating the implementation of the new service model and the framework for assessing client outcomes will assist Vision Australia as it moves forward in the amalgamation process. The mission statement of Vision Australia encompasses the pursuit of clients participating in any facet of life, and these suggestions will enhance Vision Australia's ability to internally improve, allowing the organization to achieve this goal as well as the goals of the clients.

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Nomenclature

1 AAD- Australian Association for the Deaf

2 CERA- Centre for Eye Research Australia. An organization found within the Eye and Ear Hospital but that serves also as part of the University of Melbourne. The primary focus of the center is to perform research on the eye as well as diseases and conditions affecting the eye.

3 Client Service model- an encompassment of all the products and services of an organization in addition to the manner in which services are structured and delivered.

4 Disability- results when impairment causes a person to be unable to perform tasks in a manner or in the range considered to be normal.

5 Functional Reserve- The idea that every task in life requires some amount of visual acuity. Individuals partaking in the activity will view the difficulty level based on the amount of vision they have as compared to what is necessary. For example, an individual who only needs eye glasses to read letters well will not believe the task of reading a novel to be as hard as someone who requires a magnifier. This is a difference in the functional reserve each individual has to apply to the task of reading.

6 Handicap- results when a disability hinders a person's activities of daily living.

7 Impairment- any loss or abnormality of a psychological, physical, or anatomical function.

8 IVI- Impact of Vision Impairment Profile. A tool for outcomes assessment created by CERA to specifically determine client outcomes after the completion of low-vision services or the receipt of products. It has a total of 28 questions that fall into 3 domains.

9 Key Contact- The trained VA employee that acts as a single liaison that connects VA clients to VA and its services.

10 LVQOL- Low-Vision Quality of Life survey. A survey that is numerically scaled and centers around individuals' abilities to partake in daily activities with or without visual help like contacts, glasses, magnifiers and the like. This is another survey that does not incorporate individuals who are blind without altering the questions.

11 NCC- National Contact Center, connects potential VA clients with VA or other service centers as appropriate.

12 NEI VFQ-25- The name for a 25 questioned version of a quality of life survey pertaining to individuals with visual impairment developed by the National Eye Institute. It is based around the idea of "functional reserve" and is numerically scaled and analyzed. It is not a survey that takes into account individuals who are blind.

13 OATs- Outreach Access Teams, conduct the service implementation of a normal service team across regional boundaries.

14 Outcomes Assessment- The collection and analysis of data that may indicate benefits, such as improvement in behavior, skills, knowledge, attitude, values, condition or other attributes, to individual clients or client populations during or after participating in service programs.

15 RBS- Royal Blind Society. An organization that focused its attention on New South Wales and the Australian Capital Territory and tried to make daily activities as accessible as possible for those with visual impairments.

16 RNZFB- Royal New Zealand Foundation of the Blind. An organization in New Zealand that parallels Vision Australia in terms of provided services and products. The organization has a client base of 11,500 persons and the organization expects that number to rise in the next few years.

17 RVIB- Royal Victorian Institute for the Blind. An organization that focused on Victoria before its merger into the Vision Australia organization. The organization focused on the educational and professional aspects that pose difficulties to those who are vision-impaired or blind.

18 SERVQUAL- Method of evaluating service quality as it relates to both client and employee satisfaction.

19 VAF- The Vision Australia Foundation. The main purpose of the organization was to help create equal opportunities for the visually impaired by organizing housing and eliminating unfair practices like the "travel bond".

20 VF-14- A survey originally created to assess the ability of those with visual impairments to partake in daily activities. Originally, it applied mainly to individuals suffering from cataracts but has now become a basis for other quality of life assessments stretching beyond only cataracts.

21 VisQoL- A survey specifically tailored to identifying the quality of life of individuals with visual impairments. A six-question survey has been put into effect as a pre-survey to clients before they receive any services. It allows organizations to gauge what each individual wishes to gain from the experiences as the questions focus

mainly on the traditional aspects of life such as reading, cooking, educational related activities, etc.

1 Introduction

Blindness and low vision affect an enormous number of people across the world. Over 45 million people suffer from blindness and an estimated 3.1% of all deaths stem from risk factors associated with vision impairment (Uniteforsight, 2007). The visually disabled experience difficulties when traveling to school, maintaining steady work, and when otherwise fully participating in society. Understanding the origin of these problems and developing everyday solutions is essential to the well being of the visually impaired (Uniteforsight, 2007).

Vision Australia (VA) is a non-profit organization with the purpose of serving individuals that suffer from low vision and those that are legally or completely blind. Vision Australia provides a variety of services, including products such as Braille decoders and services that include occupational training and home navigation strategies. VA also provides personal services and tutorials that assist in daily activities such as mobilization around one's home or office, and even programs tailored to functioning in a work environment. The current organization emerged in 2004 as a result of the merger between three individual non-profit organizations: the Royal Victorian Institute for the Blind, the Royal Blind Society, and the Vision Australia Foundation. With thirty-three service centers across Victoria, New South Wales, and the Australian Capital Territory, Vision Australia served nearly 41,000 individuals in 2006.

Prior to the merger, each organization had its own methods for delivering services and products to their clients based on specialized systems for determining client needs. Since these methods differed in application and success rate, Vision Australia is currently striving not only for a unified service model in terms of deliverables to their clients in all of the participating areas, but also a method to obtain feedback relative to the services and products from which the clients benefit. VA, especially as a new organization, needs a set of valid and efficient methods by which to track client outcomes following the provision of services and products.

The development of various types of feedback methods and the manner in which these relate to the service model currently being implemented by VA is essential. Also, identifying the intent of Vision Australia's services is integral to understanding the outcomes that this project seeks to optimize. Furthermore, the quantification of client outcomes across a diverse spectrum of clients, services, and service center locations serves as a daunting task.

Vision Australia, as a newly merged organization, spent much of the first year successfully reorganizing and integrating a more unified structure to the service model and tailoring it to fit their larger range of clientele. It took until December of 2006 to initiate implementation of the new model. The organization required a method by which to evaluate the effectiveness of the service model in terms of overall client satisfaction and outcomes. With this information, VA can make strides to optimize their client outcomes and implement a system for continuous improvement for all of their clientele. VA is essentially looking to ensure that its intent for the outcomes of the service model is congruent with the eventual impact.

The mission for this project was to serve as a stepping stone for VA in their efforts to develop a unified client outcomes evaluation model. To better help VA, this project group created tailored suggestions for the organization to implement at a later time and determined the best fit for their decided needs. In pursuit of achieving these goals, this team:

- Analyzed both archived data from the pre-merger organization to observe which techniques for measuring client outcomes are most successful (successful in this manner refers to the degree to which the intent for a particular service is congruent with its impact on the client);

- Interviewed VA employees to extract ideas gained from personal interaction with clients that would be beneficial to improving overall experiences for both client and provider;

- Provided Vision Australia with framework suggestions for qualitatively evaluating client outcomes; and

- Analyzed the information obtained through the aforementioned strategies and develop a framework for the assessment of client outcomes.

These measures will assist Vision Australia in realizing the full meaning of its mission statement in which establishing a system that enables the blind and vision impaired to participate in any facet of life that they choose is accomplished.

2 Background

Developing a framework for assessing client outcomes includes a broad range of related topics. First and foremost is an understanding of Vision Australia's history and the unification process of three organizations in a recent merger. As this project sought to identify relevant methods by which to assess client outcomes, it was imperative to understand if client outcomes was a unified concept held by VA or if variations existed from the merger.

It was also important, in order to create a working evaluation technique, to understand the scope of the current service model being implemented and what constitutes success in the eyes of the clients, service providers and management. Through understanding what products and services are offered and available to individuals, it becomes possible to develop goals about ideal outcomes for the clients at the conclusion of the service provision. Building on this fact, having rational goals allows for a more unified concept of what constitutes as satisfactory or appropriate client outcomes from which evaluations can be derived and used.

Additionally, outcomes assessment strategies were investigated not only on the level of options which are both available and feasible, but must also to take into account prior successes and failures of models used in the pre-merger organizations. Implementation evaluation techniques and the concept of client outcomes are readily found in many non-profit organizations both domestically and abroad. Understanding the successes and failures of each method and how these methods relate to the visually impaired and blind client backgrounds would create a more unified and viable evaluation model necessary to optimize client outcomes as VA demands.

The following information is a summation of research relative to the topics described above.

2.1 Vision Australia

2.1.1 History

Vision Australia is an organization stemming from the recent merger of three organizations on July 7, 2004: the Royal Blind Society (RBS), Royal Victorian Institute for the Blind (RVIB), and the Vision Australia Foundation (VAF). Prior to the merger each organization provided aid to those with low vision and blindness for more than 100 years. Over the years, RVIB, RBS, and the Vision Australia Foundation adopted particular niches from which to serve the specific needs of their clientele (Vision Australia at a Glance).

The Royal Victorian Institute for the Blind (originally the Industrial Blind Institution) was the first organization founded and primarily focused on economic reparations for individuals with vision loss. Reverend James Miriam, who was blind in one eye, began the organization in 1866 as a way to help others in the same situation. His main focus was to allow individuals to gain vocational skills necessary to acquire a job in the competitive economic world. This organization grew in size as more and more individuals realized that the skills and products offered through the RVIB would allow them to acquire jobs and participate in several new aspects of everyday living.

The RVIB also developed educational tools to provide visually impaired students with the same higher education opportunities as those more visually fortunate. Tilly Aston, a blind student of the RVIB, was gifted academically but required additional help to matriculate into a traditional university. With the help of RVIB, she was accepted into a university and rose to the top of her class. However when she arrived at university, Ms. Aston found that RVIB could not prepare her or any other visually impaired student for the extra work necessary to translate the required text books into Braille. Tilly spent more of her time translating the material than actually learning. In an effort to change this situation for students to come, Ms. Aston established the first Braille library which is now part of the Vision Australia organization (Vision Australia's History). This library's main focus is to offer educational material in formats accessible by visually impaired students in an effort to acquire the same educational opportunities as sighted individuals. At the height of the RVIB, the organization catered to 4,000 low-vision and blind Victorians in educational and work oriented environments while offering the Braille library services to 7,000 individuals (Royal Victorian Institute for the Blind, 1999)

The Vision Australia Foundation (formerly the Association for the Advancement of the Blind) provided a unique set of services and opportunities to the blind and vision impaired that the RBS and RVIB lacked. At the time of its founding in 1909, many individuals with various forms of vision loss were homeless due to the lack of available jobs and educational assistance. In an effort to combat this, the organization built care centers for homeless individuals suffering vision loss. The organization developed as the need for these homes grew (Vision Australia's History). Beyond the scope of shelter for the homeless, VAF also fought prejudices against the blind such as the exclusion of blind individuals from voting. VAF in these aspects was a multifaceted organization that provided the blind and visually impaired with opportunities to exercise their rights as Australian citizens.

At the inception of the Vision Australia Foundation, blind Australian citizens were not allowed to vote. They were seen as not being capable of making important decisions for the benefit of the country. They were even referred to as undesirable people and treated with prejudice. For example, blind people were often required to pay a 'travel bond' (Stories of Vision). This bond was an additional fee or 'ranging value' imposed on blind travelers using any transportation method. Blind clientele were forced to pay a fee in addition to the usual tariff simply because the transportation companies assumed that providing transportation to blind passengers would result in a decrease in the number of paying customers that were not visually impaired. The Vision Australia Foundation was responsible for both the acquisition of voting rights and the abolishment of the "travel bond," a step closer to the abolishing of discrimination (Stories of Vision).

The Royal Blind Society was the third organization involved in the merger. It was originally formed in 1879 and named the Sydney Industrial Blind Institution in order to provide aid to children and adults living with the affects of vision loss or blindness (Royal Blind Society, 2003). The RBS primarily focused its efforts in New South Wales and the Australian Capital Territory and at its peak provided aid for 1,600 individuals of differing levels of visual impairment. The primary focus of the organization was to allow access for those with vision impairment into traditional society. In other words, RBS wanted to offer services and products that allowed low-vision or blind clientele to integrate into normal daily activities such as working and navigation around communities (Pickett, 2006).

The decision to become a unified organization under the name Vision Australia came from the idea that together with the National Information Library Service (NILS), as a cohesive organization, these three agencies could provide more assistance to their blind and vision impaired clients. The NILS was not considered in this research as it did not contain a client services component. As each organization had specific goals for the way they aided visually impaired clients, the amalgamation would allow for a more complete assistance to visually impaired individuals.

Because the pre-merger organizations were all well established, the first order of business was to create a unified concept of client services. The Vision Australia organization decided to focus on a broad range of concepts and factors affecting the daily lives of the clientele. The first was to ensure that the organization would provide all available and up-to-date information in a manner that was accessible to their clientele regardless of the level of vision loss. This information could be anything from information concerning new products and available services to upcoming conferences and fundraisers.

Vision Australia also wanted to be able to create and provide as many tools and learning experiences as possible, so that their clients could fully partake in all aspects of life from which they may have previously felt excluded, such as sports, driving, education, and mobility. Vision Australia wanted not only to provide technical products such as Braille readers and high powered magnifiers, they also wanted to create programs that allowed clients to learn how to function in everyday situations and to overcome any unexpected problems they might encounter on a day to day basis due to their level of vision loss. Ultimately, Vision Australia's mission is to offer every advantage to their clients that would be conducive to the enabling of full function in everyday society.

2.1.2 Current client service model

The Vision Australia client service model, according to the literature published by VA, describes the possibilities of delivering a flexible and uniform service model to all clients across numerous service centers. The intended deliverable of the service model is a common service delivery approach that allows for flexible implementation of services and increased client independence. VA's service centers used to provide differing service implementations, and the care of the clients was inconsistent when multiple services centers provided assistance to a client (Vision Australia Model Document, 2006).

In an effort to unify service provision, the service model outlines the five overlying issues of client services. These include understanding the well-being of both the client and the client's family, recognizing that client age impacts the duration of service implementation, ensuring that client care will take place in a service network that spans the entire organization, providing services irrespective of location and past practice, and delivering services through teams of trained professionals and volunteers. This provides the client with the feeling that they are a client of Vision Australia and not one of many service centers and also allows the clients to have control over the path of service that is employed.

CYCLE OF SERVICE

Initial General Contact
Multiple Points of Entry

Formal Referral

No Formal Assessment

Basic one off request for information or non-specialist aid.
Post Code requested, offer of being on mailing list and Vision Australia contact no. given

General Request for Service

Preliminary Screening
Low Level Assessment
Core Competencies

Specific Request for Specialised Service

High Level Assessment

Specialist Competencies

Person-Centred Service Planning & Co-Ordination
Key Contact Worker
- Home, School, Work, Community
- Centre based
- Clinic based

Service Provision

Service Modules

Short Term
< 6mths

Medium Term
6 – 12 mths

Long Term
Ongoing
> 12 mths

Low Intensity | High Intensity

Low Intensity | High Intensity

Low Intensity | High Intensity

Monitoring Review

Figure 2: Service Delivery Cycle

2.1.2.1 Service delivery

The general service cycle for Vision Australia clients includes initial needs assessment, planning of services, service delivery, and outcomes follow up. In the best interest of the clients, a defined a set of characteristics for the service model was established (Figure 2). These included easy location of the nearest service center, having a key contact that would serve as a point of contact between the client and Vision Australia, and access to peers with limited or no vision.

2.1.2.2 Initial contact with client

In addition to calling and visiting local service centers, visually impaired individuals can call a toll free Vision Australia number, the National Contact Center (NCC). The NCC will connect the caller to a service center, which will have the technical capability of connecting calls to other service centers. Initial contact personnel within Vision Australia must be trained for competency using an internally-devised program. In additional, VA must have the technical capacity to electronically transfer client files in a timely and efficient

manner in an effort to expedite the next step, service planning. It was later established that the implementation of the Integrated Client & Volunteer Management System will sufficiently meet this need.

2.1.2.3 Service planning

Upon entering the system through initial contacts such as the NCC, the client's service pathway is devised through the intervention of a key contact who is a trained staff member of Vision Australia that mediates the relationship between the client and the organization. Key contacts must know how to access the client database and also have a full knowledge of the service modules and the cycles of client service which they must facilitate. In addition, key contacts must be familiar with the services provided in the community that are independent of Vision Australia. Client input is essential to the planning of future services. During the planning process, the client should manage the direction of the services to be received as much as possible. Once the terms of service have been identified and a plan of service provision has been established based on the needs of the individual, the key contact must then record the decided service package and provide a copy to the client that is easily accessible.

2.1.2.4 Delivery of services

Service delivery is divided into three periods: short term (less than six months), medium term (six to twelve months), and long term (twelve months or more). With each epoch of service comes an array of services, some of which are applicable in more than one service period. The period of service is a function of both the client's age and the extent to which the client requires services.

The service model mandates that service delivery be conducted by service teams. One type of service team is a multifaceted service team that has a universal knowledge of VA's programs and has people that can provide all of the core services as outlined in the service model. The other type of service team is specialized to handle low incidence disabilities such as deaf-blind clients. The staff on the service teams will be internally trained with the intent that as a group, the full realm of core services can be provided. Each service provided by VA will have a contact from the service teams that evaluates the service and impacts quality control. Service team members may also serve as the key contact, provided that they have completed the necessary training.

This approach allows for a consistent point of entry into the VA service cycle and the propagation of unified information. It also encourages the participation of volunteers and VA

staff in addition to ensuring that anyone that has direct contact with the clients is fully knowledgeable of the services provided by VA. Lastly, the key contact followed by the service team approach allows for a smoother integration of peers and role models into the service implementation.

For clients that live in areas that are not in the vicinity of a service center, Vision Australia developed Outreach Access Teams (OATs). These teams conduct the service implementation of a normal service team across regional boundaries. OATs also serve an advisory role to the local service teams. At the time of publication of the client service model, there were five OATs, one for each region defined by VA. Outreach Access personnel are kept on standby in the event that new clients enter the system and require assistance while others rotate in circuits of clientele that reside outside of Victoria, New South Wales, and the Australian Capital Territory.

2.1.2.5 Service model implementation themes

Vision Australia provided, in its original client service model document, ten core service areas which are encompassed by the whole service model. These services were: Services for Children and Young People, Education Training and Employment, Recreation and Social Options, Independent Living Solutions, Orientation and Mobility, Equipment Solutions, Low Vision Services, Deaf-blind Services, Counseling, and Information and Community Awareness. These areas were described as encompassing of the realm of services provided by Vision Australia.

Nearly four months after the release of the original client service model document, Vision Australia drafted a corollary which detailed the shift in attention from core services to the themes of service provision based on the needs of clients. These are: Information, Emotional Support, Independence at Home, Independence in the Community, Education, Employment, and Communication Tools. These themes of service will encompass the aforementioned service modules in an effort to expand the possibilities of Vision Australia's services.

The service modules that fall under each theme will be developed by action teams, groups of service personnel from an array of service centers that are lead by a team leader, in conjunction with the eight senior client service managers (CSM8). The service modules developed by action teams will provide a basis for a service directory, which will collect all of the service modules to provide a conglomerate resource for clients and staff to understand

the full spectrum of VA's services. In addition these directories will provide a single, organization-wide language for service delivery in addition to common assessment tools.

Action teams and design groups are the working groups that were mentioned in the original client service model. Design groups are members of the CSM8 or local managers that meet on organizational issues such as fee of services, eligibility for services, and exploring avenues for continuous improvement. The team structure and hierarchy resemble that of the design teams. The modules designed by these teams encompass what the organization plans to implement, not how it will accomplish the modules. The means by which the modules are implemented will be flexible, congruent with the mission statement of the organization through which flexible and affordable service provision is made possible.

2.1.2.6 Peers, role models, and mentors

The presence of peers, role models, and mentors provides for an affiliation between sighted and visually impaired individuals. As clients develop personal relationships amongst themselves an increase in independence results because these interactions increase the client's comprehension of vision loss and simultaneously stimulate everyday interactions. This enhancement of independence allows the vision impaired to begin participation in many facets of life, which follows the goals outlined in Vision Australia's mission statement.

According to the service model peers are the blind, visually impaired, and caregivers that provide a support system for individual clients. Formal peers are trained internally to support the clients in a one-on-one setting or a group setting. Informal peers are peers that do not necessarily receive training and their presence in the support circle of the clients is variable. This forum provides the client with a sense of belonging while at the same time supplies Vision Australia with qualitative information regarding client outcomes than can be analyzed while evaluating the service model.

Role models serve a purpose similar to that of peers. Role models are almost always visually impaired, and must complete an initial training period to prepare for daily client interactions. A mentor has a slightly greater role, in that they are in charge of facilitating the growth and learning of the client. Typically individuals that share similar experiences with the clients are mentors.

2.1.2.7 Service model evaluation and continuous improvement

Vision Australia has determined that a periodic review of the service delivery model will be conducted by the working group, which is knowledgeable in the fields of all services. The scheduling of these reviews was not determined at the time of publication. In addition,

Vision Australia planned to meet with caregivers, clients, family, and staff members to gauge the extent to which the service model was executed. Lastly, an outcomes evaluation would be developed by the Client Services Management team. While Vision Australia is strongly committed to ensuring optimal client outcomes through continuous improvement of the service model implementation, the model document does not detail how these will be accomplished in greater detail (Vision Australia, 2006).

2.2 Client service models and outcomes assessment

2.2.1 Client service models

Developing and implementing rigorous client service models is a large undertaking for any company or organization; VA is no different. Ideally, a service model is a rubric by which services or products are offered based on appropriate criteria. For VA, this means that if individuals have the same level of vision loss and participate in the same activities, they would be offered the same products and services throughout the organization. The model would be tailored to the needs of the client through the key contact, since a flexible service delivery is conducive to the purpose of the service model. In order to create service models that are beneficial in this manner, however, the concept of service must be better understood and implemented.

The definition of the word service, in its applications relative to users and customers, is difficult to clearly define. According to the work of Garschhammer *et al.* (2001), service describes the set of actions between the user and the provider. The meaning of service must be viewed by both the client and the provider in the same manner in order for the service to be most effective. Also, the quality of service is measured both quantitatively and qualitatively. For the purposes of Vision Australia, the aforementioned advice describes obtaining information not only about the duration of service and a subjective response regarding satisfaction but rather a developing a gateway to improvement through personal outcomes assessment.

In another work by Garschhammer *et al.* (2001), an emphasis is placed on a differentiation between service and service implementation. A national organization may outline a service model that its constituent service centers are expected to follow, however this should not restrict the creativity of the individual service centers in providing the best service for the clients of the agency. The authors go on to discuss the importance of feedback with regards to the entire experience of the client. Vision Australia implements an eight step process, from initiating contact all the way through each of the services provided (Vision

Australia Service Model Document). Each of these steps and the smaller components of the steps should be kept in mind when comprehensively evaluating the experience and eventual outcomes of the client.

According to a study by Enos (2003), service providing organizations are more concerned with the available treatments than the actual needs of the client. This exemplifies the disjunction between the desired outcomes for the client as viewed by the organization and the expected outcomes of the client. A greater focus needs to be placed on determining what clients want and how to achieve those results rather than on developing products and services. If an organization tailors the service model they have implemented to the desired needs of the client and fits the necessary products into that framework the results will be two-fold for the organization and the individual. First, and most obvious, the client would receive a service that directly meets their needs. Also, services tailored to the client provide the beneficiary with a sense of empowerment that not only increases client satisfaction but can also ease the minds of clients that were coerced into seeking assistance. Further still this should efficiently optimize client outcomes, as the organization will not waste time or valuable resources providing services that are ultimately ineffective.

Enos went on to discuss other features of a client service model that can assist in the maximization of client outcomes. A feedback module that can effectively allow the clients to participate in the changing process is essential to a successful experience. Another interesting approach is initiating a journaling process by which the clients record activities and feelings throughout their treatment or use of services. The journal not only instills a sense of ownership and responsibility within the client but developing a quality journal could increase the level to which beneficiaries feel appreciated, resulting in quality feedback and outlets for improvement (Enos, SR30-SR31).

2.2.2 Outcomes measurement

The goal of program logic and outcomes measurement, which describes a type of outcomes evaluation structure, is to determine if a service program fulfills only the quantitative achievements of client outcomes, like the number of clients serviced or how many hours they participated in a program. According to Plantz, Greenway and Hendricks, outcomes evaluation is intended to measure "changes in the participants' knowledge, attitudes, values, skills, behavior, condition, or status." (Bozzo 2000) This seems to indicate that the most important outcomes measurement is the change that any given set of services makes for the beneficiary, rather than the more quantitative aspects of service delivery.

Research on service evaluation resources available to non-profit organizations indicates that less technical data collection and analysis techniques may be more suited to non-profit organizations due to the fact that they may lack the capacity or experience necessary to implement the technical data acquisition methods needed for program logic and outcomes measurement without consultation of outside firms (Bozzo 2000). In addition to more simplified data collection techniques, it is important that executive leaders of any organization be flexible enough to allow those directly involved with the services in question to have more control over the parameters of the evaluation.

Participatory evaluation models use a combination of staff, volunteers, clients and others involved with the organization to provide information about the way the service program is developing and performing as it moves forward. The overall aim of such methods is focused on facilitating continual improvement of the program in an effort to generate greater individual client outcomes. Disadvantages of this type of evaluation are the amount of time and resources that must be allocated to the process to ensure a meaningful result and the fact that the method's lack of structure requires experienced facilitators to maintain the focus of discussion (Bozzo, 2000).

Another type of evaluation known as the balanced scorecard method centers on evaluating and improving organizational efficiency and facilitating continual improvement of the program model. The balanced scorecard method is an approach by which every facet of the service model is evaluated to the same degree. Balanced scorecard evaluations are more commonly found in the corporate sector because they focus very little on outcomes and more on different components and principles of the organization and its programs (Bozzo 2000). This method also encourages the organization to be more business-like in terms of funding and administration. For this reason, the approach may not be advantageous to non-profit organizations, as organizational and administrative philosophies differ between the non-profit and corporate sectors. The corporate sector tends to use high efficiency standards as a basis for improvement, which may not apply for non-profit organizations looking to proliferate and supplement the programs and services they offer to generate good client outcomes. Additionally, the balanced scorecard method requires staff conducting the evaluation to be well trained and have in-depth knowledge of the internal components of the organization such as internal business, donor satisfaction, customer satisfaction, and enhanced learning and growth. This may be an obstacle for non-profit organizations that lack the resources to train, manage, and successfully implement the balanced scorecard technique (Bozzo, 2000).

Another well known and widely used method of evaluating service quality as it relates to both client and employee satisfaction is "SERVQUAL" (Koornneef, 2006). SERVQUAL uses a 22-item scale that assesses the expectations of customers versus the quality of service received. "It is designed to measure service quality, i.e. the comparison between consumers' expectations with their perceptions of actual service delivered" (Koornneef, 2006). If a consumer has high expectations for a service, and that service meets those expectations, then such a result can be seen as a successful outcome because it is likely that the client got something out of the service.

SERVQUAL uses five core dimensions of service quality: tangibles, reliability, responsiveness, assurance and empathy. These dimensions are then measured through 22 questions, in the form of a questionnaire, dealing with the difference between an excellent service and the service that is actually provided. Each question is then given two sets of scores (ranged 1-7) by the participant; one for the expectation of service quality and the other for the perceived service received. The differences between the scores are the "gaps" that define the difference between what was expected and what was given. The questionnaire has an additional three questions about demographic, and whether or not the participant would recommend the services to a friend. Questionnaires for the staff, employees and volunteers are constructed similarly (Koornneef, 2006). This method is ideal for non-profit organizations looking to improve client outcomes because the subject of the entire questionnaire is the congruence between service expectations and the actual outcomes. This is especially beneficial to organizations such as VA that rely heavily on client outcomes to determine where improvements can be made.

2.3 Domestic and international approaches to outcomes assessment

In order to develop framework suggestions for the service implementation and furthering client outcomes, it is essential to study the methods that more established organizations have developed in addition to their intended outcomes to insure congruency between the desired information and solutions each evaluation method provides. Some organizations directly assist persons with vision impairments whereas others assist other genres of persons with disabilities and some have nothing to do with personal health at all, however these share a common purpose in analyzing and maximizing client outcomes. Service organizations use feedback and outcomes assessment modules, and through

understanding these it is possible to make recommendations that will strengthen the client outcomes assessment tools used by Vision Australia.

2.3.1 Australian Association for the Deaf

The Australian Association for the Deaf (AAD) is an organization that primarily started as a way to provide interpretations in a medical setting when necessary to deaf individuals of the community. It was determined by the organization that interpreters were in greater demand beyond just medical needs. There was a demand in the legal and education fields as well with an ever-expanding clientele base. As funding for all of the programs results from donations from the Department of Families, Community Services, and Indigenous Affairs, the organization needed some way in which to present the demand for more interpreters to the government in the form of a policy paper to receive the necessary increase in funds (AAD, 2007).

In order to accomplish this, the AAD turned to the clients themselves and asked, in both a published discussion paper as well as through the questionnaire for client views, about instances where interpreters were needed but limited in number. It was discovered that clients expressed a need for available interpreters at no charge in situations at doctor's offices, general hospitals, in education, in court, and during conferences for easier and more meaningful interactions (AAD, 2007).

Ultimately, the client feedback obtained through these methods led to a larger grant given in order to have more interpreters available for more functions. A copy of the survey used can be found in Appendix A. It can be readily seen that the questions were written in a specific manner so as to avoid as much uncertainty as possible and lead toward more viable data results. The way the questions were written paired with an understanding of the AAD's conclusions will be helpful in the formation of a related and relevant survey for VA.

The client feedback allowed AAD to determine areas that required more improvement or less attention. Vision Australia needs to be able to answer the same questions while dealing with a visually impaired clientele as opposed to a hearing impaired clientele base. The survey created by the AAD could serve as a template in this group's suggestions to VA in determining initial points of interest from their clientele. This would then allow for a better understanding of the predicted outcomes of the individuals and a clearer idea of how to assess the current service model in terms of these outcomes.

2.3.2 United Way

The United Way is a massive organization that acts as a network of more than 1,300 private organizations around the United States that work to improve the communities they serve. The United Way is also a liaison between people all across America, and human services for everyday needs and times of crisis (United Way, 2007). While the United Way itself does not conduct internal outcomes assessment, it does recommend outcomes assessment tools to the organizations it funds, and conducts its own evaluations of the many different organizations it sponsors to determine where resources should be allocated. The United Way has published several articles and manuals focused on the definition, advantages, limitations, and methods of outcomes assessment. These articles serve as basic guidelines for non-profit organizations with limited or abundant resources to develop an outcomes evaluation.

One such publication stresses the importance of developing an outcomes evaluation plan by choosing important short (0-6 months after/during service provision), intermediate (3-9 months after/during service provision) and long (6-12 months after/during service provision) term outcomes (McNamara, 2006). Also, the outcome targets must be determined. These are the number or types of clients that should realize any given outcome. An example of an outcome target might be that 80% of blind clients seeking gainful employment should find that employment in 6 to 12 months. Next, the source of information for each outcome must be determined. This source is known as an indicator and can be anything from a client survey, to statistical records kept by a government agency (McNamara, 2006). For example, an indicator for a program outcome of helping people find and keep gainful employment may have an indicator in government statistics about unemployment. It is also very important to examine the feasibility of acquiring information from any given indicator (McNamara, 2006). Information could be restricted, expensive or not recorded at all. Lastly, any information must be compiled and analyzed, be it numerical data requiring statistical analysis or qualitative data that must be read and organized by different categories such as suggestions, concerns or strengths (McNamara, 2006). These basic steps define a generalized case for developing an outcomes assessment framework. Working with many private organizations, the United Way has spread the use of outcomes assessment to facilitate continuous improvement (United Way, 2007).

2.3.3 Royal New Zealand Foundation of the Blind

The Royal New Zealand Foundation of the Blind (RNZFB) is an organization much like Vision Australia that caters to individuals with low vision and blindness in New Zealand. The organization has about 11,700 clients currently though this number fluctuates by year based on age of the population and diagnosis numbers. Over the 19 total offices there are 337 employees as well as a volunteer base of more than 13,000 (RNZFB, 2007).

RNZFB offers to its clients many of the same products and services offered through Vision Australia. There are tools for communication like Braille lessons or talking books, as well as lessons on mobility and use of aids like canes, and also councilors to help boost a client's attitude on life with the vision impairment. The RNZFB also offers access to guide dogs for clients that meet certain criteria (RNZFB, 2007).

The RNZFB, like VA, has recently decided to evaluate the impact of their services on their clients by studying qualitative outcomes. In order to do this, they recently implemented an assessment tool that can be found in Appendix H and is titled Self-Report of Function Questionnaire. This assessment tool is administered after the completion of service. The important aspects of the questionnaire are that it is not designed to be solely an assessment of services that were received. The initial sections focus on the client and their life as well as any changes they have undergone since beginning the interaction with RNZFB. After this is established, the actual impact is assessed.

This is an important aspect of the questionnaire to consider because it takes into account whether a client's vision has deteriorated further since beginning the service. The impact of services on a client can not be properly assessed if the conditions prior to and after the service provision have changed significantly. The services offered may have had a significant effect on a client had their vision not deteriorated, however, changes in the client's vision may require different services. In suggesting concepts important to outcomes based evaluation to VA, this is something very important to integrate.

2.4 Surveying techniques and client relations

The problem associated with evaluation tools is most often finding an applicable tool for all aspects under evaluation. As Stelmack *et al.* identified, the more products or services offered, the harder it is to identify a universally useful evaluation technique. In terms of VA, the organization provides everything from materials in Braille and magnifiers of differing strengths to tutorial presentations and workshops aimed at providing skills to help with client mobility. Questions posed to clients should be altered based on specific services received

and these questions should be worded specifically enough to achieve accurate depictions of the resulting client outcomes (Stelmack, 2002).

2.4.1 Pre-intervention surveys

Currently, there are several measures used in a variety of organizational environments that can apply to VA's vision impaired clientele. One concept frequently considered in the literature is a pre-intervention survey. If VA wants to be able to define client outcomes on the basis of whether the goals of both the organization and the individual were reached after the intervention, the organization and client must first have some idea of where the person's service provision began. The pre-intervention survey would serve as a baseline from which to gauge future progress or regression as well as defining what is important to the individual client.

One such survey that has been put into affect both in the United States and in Australia is a shortened version of the VisQoL. The VisQoL is a survey specifically tailored to identifying the quality of life of individuals with visual impairments. It was developed after content of quality of life measures were reviewed and current methods re-evaluated especially those pertaining to individuals with low-vision or blindness. Traditional survey types pertaining to general quality of life were reviewed and then focus groups were conducted with clients from the Royal Victorian Eye and Ear Hospital to determine the effectiveness of the way questions were asked and accuracy of the determined outcomes (Misajon, 2005).

The original survey was far lengthier than the shortened VisQoL, which was intended to be a precursor to any interventions. The pre-intervention survey version is only six questions in length and very briefly and broadly covers possible goals the client may have for their future and results of interactions with the organization. The broad questions deal with loss of vision affecting safety, daily demands, friendships, the ability to develop relationships, whether or not it is necessary to find additional help and the difficulties and finding the aid when needed, whether an individual feels left out of aspects of their life, and finally confidence in general. Obviously, these topics are broad and are open to interpretation by the clients, but regardless of the differing conceptual views, the overall result is a basis from which to work with the client.

By implementing the VisQol survey as a pre-intervention method at the time of first meeting with the client, the key contact at VA would quickly be able to determine what the client deemed to be important to their everyday life and using that information from there

determine the most beneficial tools and learning experiences that would result in the best overall outcome. This survey would also allow for a comparison of results post-intervention to quantify progress made by the individuals over time. This would be best implemented using a face to face administration at both occurrences so that discussion could be stimulated between the key contact at VA and the client. The shortened version that would best aid VA can be found in Appendix B (Misajon, 2005).

2.4.2 The LVQOL evaluation instrument

It also becomes important to implement an outcomes evaluation tool after the products or services have been rendered to the clients. There are several evaluation techniques currently in use in many varieties of both non-profit and for-profit organizations. Each of these methods, regardless of the organization receiving the feedback, is formulated as a survey. The reason behind this is that especially with VA, given the large number of clients, it would be a daunting task to implement individual interviews or studies and still receive qualitative data.

One such survey type is termed the LVQOL or the Low-Vision Quality of Life survey. Originally, the LVQOL was designed for only a clinical setting (Lewin Group). Doctors used the survey to assess patient's quality of life with certain optic diseases like glaucoma. It was successful in the setting and found to be readily adaptable outside of this medical field to include daily life activities. To date, it is predominately used in the medical profession but is also used by the Veterans Association in the United States.

The LVQOL survey is a series of questions that are answered on a numerical scale of 1-5. An answer of 1 depicts that the client has no problem with the named activity due to sight whereas a value of 5 indicates that the client actually stopped participating in the activity because of their vision loss. The questions of the survey are very specific and leave no room for interpretation or further explanation which is both beneficial and detrimental. If there is no room for explanation or greater understanding of the client's mindset, the results of the questions can become skewed and thus the results appear less accurate. However, the survey does deal with particular activities in a person's daily life and can very quickly determine which areas are lacking for which clients and lead towards a quicker and more client-specific service model resulting in the best client outcome over time. The survey can be found in Appendix C (Wolffsohn, 2000).

2.4.3 NEI VFQ-25

A second survey type is called the NEI VFQ-25, where the 25 corresponds to the total number of questions asked of the clients. This survey, as was shown by Stelmack *et al.*, took into consideration that there are many aspects that make up an overall sense of quality of life for an individual. These aspects are anything from physical abilities like being able to read or sew, to psychological aspects where an individual feels they can depend on themselves (Stelmack, 2002). When creating the survey, the National Eye Institute (NEI) considered the "functional reserve" of an individual and how that would affect feedback eventually solicited. Functional reserve, according to the NEI, is the difference in how an individual views the difficulty of a specific task or activity based on their visual ability.

For example, if an activity such as reading is considered by three people of varying visual ability; one can accomplish the task fairly easily and feels it is not an added stressor, one has adequate but not extra ability and views the task as not impossible but still difficult at times, and the third has less than adequate visual ability and thus views the task as impossible. The resulting feedback of identical situations but dealing with unique individuals will be very different (Stelmack, 2002).

To give an example of the aforementioned point, consider two people with equal loss of vision. They are both asked to evaluate the difficulty had reading a book with small print. Based on the situation, the answer should be the same from both individuals. The situations are identical and so is the loss of vision. But inevitably, there will be some variation. This occurs as a result of the individual personalities. If one of these two individuals thoroughly enjoys reading and wants to be able to do so for extended periods of time, they may evaluate the task as harder than the second individual who cares less for reading in general. This depicts the deviation that may occur.

The relationship between the questions asked in the NEI-VFQ 25 and clinical measures of vision function was measured, and Cole *et al.* concluded that the NEI-VFQ 25 serves as an appropriate measure of self-reported visual impairment (Cole, 2000). Cole *et al.* made no mention, however, that this technique could be used in cases of severe vision loss. The survey tool can be found in its entirety in Appendix D.

2.4.4 The LV VFQ-48

A related surveying technique is the LV VFQ-48, a method that considers reading in a multitude of settings, performing everyday activities such as getting dressed, and participating in recreational activities like playing sports. The main difference between the

LV VFQ-48 and the NEI VFQ-25 is the scoring method. The VFQ-48 has four questions regarding each of 48 activities. The first question asks if it is difficult to perform each of the tasks. The second question asks if each of the aforementioned tasks is difficult because of vision loss, and the third asks if the person would like training to correct deficiencies relative to each of the 48 activities. The answer choices for these questions are yes and no. The fourth question asks how the person performs each of the 48 activities, and the answer choices are with own eyes or glasses, vision devices, other senses, someone helps me, and not applicable (Stelmack, 2004).

By analyzing the results of 367 test subjects, Stelmack *et al.* confirmed that the LV VFQ-48 is both valid and reliable. Another finding of this study is that the VFQ-48 is practical for studying visual ability of individuals of moderate to severe vision loss. The other approaches to outcomes assessment accounted only for low-vision clients whereas Stelmack *et al.* confirmed this method can be effectively applied to near-normal and even blind individuals (Stelmack, 2004). The LV VFQ-48 can be found in Appendix E.

2.4.5 The VF-14

The VF-14 survey was created in the United States of America for the purpose of assessing outcomes of clients with visual impairments. "The VF-14 survey instrument offers a validated means of assessing the impairment to visual function caused by eye disease, capturing important aspects of the patient's perception of the disease that are not captured either by measurement of visual acuity or generic health status measures" (McKee, 2005). This means that the purpose behind the VF-14 survey is to look beyond the measurable aspects of client outcome and allow for input directly from the clientele. As has been briefly touched on before, two clients with identical levels of vision loss may receive the same product to help in their daily lives. Their individual views on the benefits of the product will not always be the same and can often skew results. The individuals themselves have to be accounted for; being able to find a link between what they had expected to be the outcome and the actual end situation would give more insight into the actual effectiveness of the supplied product.

The VF-14, as the name implies, is a survey with only 14 questions. Each of the questions asks the client to rate how affected they are in a given situation or activity while wearing glasses or using a visual aid they are accustomed to (McKee, 2005). As with the other surveys previously mentioned, the answers are scored on a numerical scale. For the VF-14 this scale ranges from 0, meaning the client has no difficulty participating in the given

activity or situation, to 4, which means the client cannot perform the activity at all. The survey itself can be seen in Appendix F.

Overall, the VF-14 is a very broad survey focused on only the most common daily activities. The questions posed to the clients are about their ability to read fine print, cook, fill out forms, play bingo, and other common tasks (Stelmack, 2001). This is beneficial in that the answers to such questions rarely have any need to be further explained. Individuals have a fairly defined concept of their ability to read a book or see the television. This means that skewed results and bias are less likely to occur. It is also beneficial in that 14 questions do not take a lengthy time period to answer accurately allowing for faster collection of data. Both reasons allow an easy implementation of the survey as an outcomes assessment tool, but it does have disadvantageous aspects especially towards VA.

The survey asks questions based on clients' activities while wearing glasses or using a visual aid. For the low vision clients of VA this would be appropriate but it would be useless for the blind individuals served by VA. The VF-14 is also difficult in that it only asks questions pertaining to the most commonplace tasks. There is no mention of traveling abroad, factors in the work or educational environments, or other more intricate social and environmental tasks. VA provides services and products to help their clients participate in employment, sports or higher educational environments. The VF-14 would not be able to accurately account for these outcomes. An option for VA that can be further looked into is the alterations of this proven method to incorporate the blind clients of VA as well as the more difficult daily interactions and activities.

2.4.6 Impact of Vision Impairment Profile (IVI)

As outcomes assessment has become a main focus of both for profit as well as nonprofit organizations worldwide, the assessment tools used have undergone more rigid scrutiny than in the recent past. Among methods like the NEI-VFQ 25 and the LVQoL there seemed to be one recognizable problem based on the scoring rubrics used.

In both instances, answers to questions are scored on a numeric scale of between 1 and 5 where each number represents a level of difficulty associated with the performing of a given task. Unfortunately, by using this method, it appears that all tasks are thought to be equal in difficulty to individuals having vision and therefore do not take into account variations in difficulty level even at the normal level. For example, a task like sewing is difficult for an individual having vision because of the precise work needed. It is most likely

more difficult than watching the television if the individual in question has the same amount of vision. But on the assessment tools traditionally used, there is not separation of levels.

This leads to the conclusion that the answers given on the traditional low-vision or blind outcomes assessment tools could very well be subjected to invalidation based on the inherent error. To overcome this, a study began in 2002 in the creation of the Impact of Vision Impairment Profile or the IVI designed by the Centre for Eye Research Australia (CERA).

This particular assessment tool originally had 32 questions in 4 areas. The survey method was subjected to mathematical analysis as well as test runs so as to determine the ordering and grouping of questions that fall into similar difficulty levels. As a result of this process, there are now only 3 domains and 28 questions. These areas are: Mobility and Independence which has 11 questions, Emotional Well-Being which has 8 questions, and Reading and Accessing Information which has 9 items (Lamoureux, 2007). The IVI was administered by professional interviewers to 115 selected clients of low vision to test reliability over time and validity when conducted in a variety of methods. Weib *et al*. statistically proved that the IVI "has sufficient internal and construct validity to measure the effect of vision impairment on restriction of participation in daily activities" (Weib, 2002). This study concluded that the IVI, if self-administered, would obtain similar results to an IVI survey conducted by a professional interviewer. The profile can be seen in Appendix G.

After implementation for the first time, there was a noticeable success rate in two out of the three areas that had feasible result levels and no result in the third area seeming to signify to the implementation groups that the arrangement of questions was done in a valid manner (Lamoureux, 2007).

Vision Australia could implement this method of assessment at both the beginning of its services as well as the end so as to have a standardized method of comparison. The impact, as the profile would suggest, is more readily noted using this assessment technique as it was specifically designed for low-vision clients. Again, the profile would have to be reevaluated for it to be useful to the blind clients of Vision Australia.

2.4.7 Limitations of written client feedback

For the purposes of vision impairment feedback, Vision Australia provides a wealth of services that already cater to the vision impaired. These can be coupled with the current feedback model to ensure that every client can comfortably participate in self-conducted feedback techniques. It is therefore essential to ensure that surveys, questionnaires or other

feedback tools are constructed in such a way as to facilitate the variation of their format. Digitizing these tools would make changing the format of any document as simple as possible. Products that can simplify this process include computer programs that translate text into Braille that can be printed, screen readers that scan the material on the user's computer screen and generate audio output, and magnification software that will expand the survey's text size to accommodate the client's visual abilities (Vision Australia).

2.5 Quality Framework for Disability Services

The Quality Framework for Disability Services serves as a supplement to the Disability Act 2006, a piece of legislation that details the standard by which organizations that provide services to the disabled must follow. This framework was originally put into action before the Disability Act 2006 was implemented, thus a revision of its contents was essential in 2007. Since the Quality Framework explains the increased standards for outcomes assessment, and the Disability Act 2006 contains information that is less pertinent to this study, only the Quality Framework will be analyzed.

The Quality Framework was developed in 1997, and the current edition is fully updated to ensure individualized and flexible service delivery. In addition, an approach to quality management was introduced in the revised issue. Among the standards that were identified in the new Quality Framework was the requirement that organizations measure outcomes for all clients. Also, an outcomes based self-assessment must be conducted by these organizations, resulting in an improvement that progresses outcomes for the clients. The quality monitoring mechanism by which these standards will be supervised has not been fully created and trialed. The projected initiation of the quality monitoring system (and thus the need for outcomes assessment as well as means for continuous improvement) is in 2009 (Department of Human Services, 2007).

2.6 Continuous improvement and its limitations

Continuous improvement is the evolution of a framework or model such that it is updated based on the most current evaluation data. It can also be defined as a program of broad change that is systematically planned. In the context of Vision Australia, continuous improvement refers to the improvement of the client service model based on its outcomes assessment. Outcomes assessment tells an organization what changes have been made to a client's life as a result of any services that client may have received. There are, however, limitations to what outcomes assessment can achieve. For example, outcomes assessment does not provide any information about why a given service caused any particular outcome,

and it does not prove that a given service caused any particular outcome (United Way; Plantz, Greenway, Hendricks). In this manner, any improvement that could be implemented as a result of an outcome assessment may not be realized. If an organization does not have proof that a service caused an outcome, or why it may have done so, it can be difficult, if not reckless, to make changes accordingly. In addition, a program or service level outcome does not necessarily reflect outcomes seen community wide.

One continuous improvement method that was included in the outcomes framework dealt with benchmarking. Benchmarking, an external focus on internal activities, serves as a comparison between the products and services of the organization in question (in this case, Vision Australia) to the standards met by the best in the industry. Benchmarking is a technique that entails a great deal of flexibility and adequate planning on the part of the organization. Vision Australia, while still in its infancy, possesses the potential to benefit from this comparative method (Elmuti, 1997).

In most cases, a single service does not affect enough individuals to impact community wide statistics due to the fact that such statistics are affected by many factors such as economic conditions, demographic trends, etc. (United Way; Plantz, Greenway, Hendricks). Any given outcome may be viewed as successful with respect to the service it evaluates. For example, suppose that 90% of the participants in a career training seminar found successful and fulfilling careers. This does not mean that the success of the seminar will cause the unemployment rate to drop in the surrounding community if the seminar were to be scaled up to be community wide. Therefore, it should not necessarily be scaled up, as the resources that would be needed to implement such a plan could far outweigh the positive outcomes that would be seen. This hinders continuous improvement through outcomes assessment.

Positive outcomes, as determined by the client, may be achieved through avenues other than as a direct result of Vision Australia's service provision, complicating evaluating outcomes in terms of continuous improvement. According to a study by Segal *et al*. an outcomes-driven organization should strive to actively include clients in its operation. Through "organizational empowerment" and allowing the clients to control their interactions with the organization, positive outcomes that are most likely to result from the client's service provision can be achieved (Segal, 2002).

3 Methodology

This project developed a structured framework for outcomes assessment of Vision Australia's clients in addition to evaluation strategies for the implementation of the new client service model. The deliverables, then, included framework suggestions for outcomes assessment that can be used in a cycle of continuous organizational improvement and provide definitive measures by which client outcomes can be measured.

This project accomplished the goals described above through the following set of objectives:

- The project team reviewed a substantial amount of literature in addition to interviews to characterize how service models are evaluated and implemented in terms of client outcomes.

- A contrast was developed between the service models of the Royal Blind Society, the Royal Victorian Institute for the Blind, and the Vision Australia Foundation with the current model for Vision Australia to further comprehend the systems prior to the merger to aid in evaluating the implementation of the new service model.

- Critical analysis of the client service model of Vision Australia was undertaken to discern which areas were misunderstood by the service provision personnel in an effort to clear up communication discrepancies between the management and staff at the individual service centers.

- Local and national non-profit organizations were examined in an effort to compile evaluation and service model implementation techniques that could effectively be applied to the suggestions for the service model implementation evaluation.

- A framework was developed in pursuit of assessing client outcomes based on a compilation of qualitative surveying techniques, suggestions made by client focus groups, and requests from senior management.

The aforementioned objectives were accomplished through the execution of the following data collection and analysis techniques:

- Interviewing representatives from the senior management group and local management at Vision Australia to discern the intent of the client service model and what measures must be taken to ensure it is implemented to the fullest.

- Comparison of the service model implementation techniques used by former RVIB, VAF, and RBS service centers to determine which obstacles need to be overcome prior to the implementation of the new model.
- Conducting focus groups with Vision Australia clients to discern the methods of outcomes assessment that are convenient for clients in addition to forming a definition of client outcomes at the client level.
- Exploring the surveying and outcomes data acquisition techniques of VA in comparison to an array of qualitative surveys to determine which attributes are essential to the client outcomes evaluation framework.

The timeline for this project is described in Figure 3. Some research was initiated in the preparatory phases of the project, which was conducted prior to arrival in Australia.

TASK	WEEK							
	PQP	1	2	3	4	5	6	7
Review of literature	■	■	■	■	■	■	■	
Interview preparation	■	■	■					
Conduct interviews with executives			■	■	■			
Conduct interviews with VA service staff			■	■	■			
Conduct focus groups with blind and low vision individuals					■			
Review existing assessment and survey instruments	■	■	■	■	■	■		
Develop methodology for assessment of implementation					■	■	■	■
Develop outcomes assessment framework						■	■	■
Final documentation (project report and presentation)						▫	■	■

Figure 3- Methodology Timeline

3.1 Critical analysis of the current service model and its implementation

Vision Australia created the client service model in an effort to fulfill the goal of its mission statement, which is to allow its clients to actively participate in all areas of everyday life. This goal, according to the literature that describes the service model, is accomplished through the implementation of an organized structure by which the client is assigned a key contact (a trained staff member of Vision Australia) that directs the service provision of the client. Other aspects of the service model structure include consistent monitoring of the client's progress towards the determined goals, follow-up on whether or not the client has established additional goals, working groups, and service teams, specialized groups of VA staff that are trained to provide the core services (also outlined in the service model literature) in a team environment.

3.2 Assessing client outcomes

As Vision Australia has a clientele base of over 41,000 people across New South Wales, Victoria, and the ACT, understanding the needs of such a diverse client base becomes a daunting task. By evaluating an array of surveying techniques, which are typically cost effective and simple to conduct, ideas for the client outcomes evaluation framework became known.

The outcomes assessment framework was necessitated by VA due to the wide client base of differing levels of vision loss. These differing levels needed to be reflected in the assessment technique suggested to VA an in effort to assess client outcomes. When looked at from an analytical standpoint, the surveys reviewed each had something different to offer VA based on the given situation.

In addition to forming comparisons between task oriented and quality of life outcomes evaluations, there were also comparisons made about the different timings of the surveys. Vision Australia has explored both pre-assessment tools that would be conducted before any products or services were rendered as well as post-assessment tools that would be administered after the service provision. These types of surveys were analyzed to determine whether or not client outcomes evaluation techniques were time sensitive. Offering a pre-assessment survey, which is designed to initiate conversation as to what is important to the client in their dealings with VA would be of little importance to the findings of a post-assessment survey which involves no direct contact with the client. The duration of review for these surveying techniques can be found in Figure 3.

The final outcomes assessment framework took into account the differing needs of the clients as well as what the clients intended to gain from their experiences with VA. The outcomes evaluations conducted by VA should take into account both the technique used to evaluate outcomes (task based vs. quality of life) in addition to the timing of the evaluation to ensure that further service provision is not required.

3.3 Interviews

It was important, in accomplishing the two objectives of the project, to obtain information concerning outcomes assessments and client service model implementations from managers and staff in each of the three pre-merger organizations. Within those models it was also essential to sample the service provision disciplines. In terms of a specific number of interviews, the issue was determining a feasible sample that would allow each pre-merger service model and each service discipline to be equally represented. Within each service center there are traditionally two staff members of each type of service provision. The exception to this was with the service coordinator position that varies based on pre-merger organization in addition to the orthoptist position.

Due to differences between the original service models, former RVIB offices had only one service coordinator while old VAF offices distributed the task of service coordination amongst all personnel. This difference in service coordination meant that interviewees specializing in service coordination were chosen from the same pre-merger model across multiple offices, where other service provision personnel were not interviewed.

It was also important to note that not every service center was of equal size and therefore differed in total workload on any one individual. These differences in workload lead to differences in opinion and even concerns about the new client service model. Using VA's Statistical Information Database (SID), it was possible to get a one year estimate of the total number of clients receiving services in each of the local government regions that house the 33 service centers of VA. Using the numbers found as an indicator, a large office and small office from each pre-merger service model were chosen. These included (but were not limited to) Canberra and Coffs Harbor from the RBS model, Boronia and Heidelberg from the RVIB model, and Kooyong and Mitcham from the VAF model. The centers that were too far away to travel to were contacted through telephone interviews.

Since one service facilitator from each field of service was chosen from both a large and small service center, it follows that approximately 10 personnel from each of the three pre-merger service models were interviewed. This totals to 30 service provision personnel.

Although the total number of service personnel in all 33 service centers is approximately 450, it is not always necessary to obtain a large sample size if each type of interviewee is represented as equally as possible, and if it is safe to assume that differences in the information gathered within each group would be small (Herek, 2007).

3.3.1 Development executives

Interviews were conducted with development executives within VA to gauge the intent as well as the implementation of the client service model. One of the project liaisons, Graeme Craig, is a member of the senior management team that served an integral role in the creation of the new service model. It was essential that information be sought through the highest possible level of an organization, as this upper echelon provided the most access to the implementation techniques of the service model across VA's service centers.

Interviews with the VA developmental staff, Mr. Craig included, supplied information regarding the rationale used in the creation of the new service model in addition to surveying and customer relations strategies that VA had employed in the past. In addition, executives from the pre-merger organizations that are currently with Vision Australia provided general definitions of client outcomes that could be compared to those from the other levels of the organization. The general interview format for these personnel can be found in Appendix I.

The approach to the interviews began with acquiring more background information regarding the specific position held within Vision Australia as well as in the pre-merger organization where they were previously employed. It was essential that the project team discover how the service models were evaluated in terms of client outcomes so as to make credible suggestions to VA at the completion of the project.

3.3.2 Working groups

In addition, the service model literature discusses the formation of working groups, which were responsible for creating and evaluating the standard to which the core services are delivered (Vision Australia, 2006). Members of these working groups were service personnel in many of the large offices selected in the interview sampling process.

Equally important was understanding the methods by which the service model was to be executed. Through interviewing the executive personnel that would oversee the implementation of the service model and the local service center staff that would directly implement the service model, misunderstood areas of the new service model were uncovered. One of the main goals of this project was to provide suggestions for the evaluation of the new service model, and if the model was not clear on the instructions by which it was to be

implemented client outcomes could be impacted. Correcting these areas of misunderstanding between the executive personnel and the service provision personnel allows for possibility of continuous improvement.

3.3.3 Key contacts and local VA personnel

Another interesting group within Vision Australia is a group that dealt with the clientele on a day-to-day basis such as service provision staff and key contacts. Interviewing these individuals provided insight as to how client outcomes are defined and evaluated across the service centers of the pre-merger organizations (questions posed to these personnel can be found in Appendix I). These interviews also resulted in an influx of qualitative information regarding the likes and dislikes of the clients when assessing outcomes, such as possible assessment tools as well as concerns with the new client service model which aided in the effort to develop relevant suggestions for outcomes assessment measures.

Lastly, a concern that was essential to address in a forum such as an interview concerns confidentiality. Understanding the patient confidentiality codes of VA and how best to abide by them while gaining accurate and pertinent information was essential to the overall success of this project.

3.3.4 Focus groups

During the development of the client service model, Vision Australia conducted an array of focus groups with a selection of its clientele to discuss what issues needed to be addressed when creating the service model. This was an open forum that allowed for feedback in both a quantitative method as well as a qualitative outcomes form. The clients commented on which outcomes (ability to read, drive a car, etc.) were of the most importance to them, providing an avenue for VA to develop a service model that encompassed the needs of the clients.

These discussions with clients were conducted during a single week, as shown in the project timeline of Figure 3. The confidentiality issues regarding the information gathered from clients were explored at great length before scheduling any client-based focus groups. The general points of discussion that were touched upon in these focus groups can be found in Appendix I.

3.4 Evaluating outcomes in terms of continuous improvement

For an organization such as Vision Australia, continuous improvement serves as a progression in client outcomes on a long term scale. Numerous resources pertaining to

continuous improvement have been explored and integrated in the later stages of the framework for evaluating client outcomes. Developing a framework for outcomes assessment that encompasses an avenue for continuous improvement is essential to the optimization of client outcomes and allowing the clients of Vision Australia to fully participate in any facet of life that they desire.

3.5 Literature and data research

3.5.1 Archival service model research

While the structure of the current service model is intended to optimize client outcomes, Vision Australia's pre-merger service models also included strategies that could improve client outcomes. Using archival data research methods, the service models of the Royal Blind Society, the Royal Victorian Institute for the Blind, and the Vision Australia Foundation were carefully examined.

The Vision Australia service model document was analyzed on the basis of important overlying concepts as dictated by service providers and senior management. These concepts were then compared to the pre-merger organizations service model documents. These models were compared for similarities and differences involving the main concepts of the new model in an effort to determine evaluation techniques for the implementation that would be effective.

In addition to researching archival service model information, the tools used to assess client outcomes were also a valuable reference to determine what techniques have been employed in the past. In addition, these indicated the areas in which they may be improved or tailored to fit the new client service model. Understanding the methods employed by the pre-merger organizations was beneficial to creating a comprehensive outcomes assessment framework.

3.5.2 Literature review

The literature review that was conducted in the United States prior to arrival in Australia did not provide the entire spectrum of tools necessary to present suggestions for an evaluation framework. Literature reviewing was performed at great lengths during the first several weeks in Australia. Not only did this project group have to search for literature suggested during interviews and focus groups, but there were still gaps in the literature review that had to be addressed upon arrival in Australia. These included, but were not limited to, the outcomes measurement and service model assessment strategies of non-profit

organizations in Australia and New Zealand (Royal New Zealand Institute for the Blind, Australian Association for the Deaf, etc.) as well as the facets of continuous improvement that were essential to the framework for outcomes assessment.

There were also pieces of literature in Australia that were initially inaccessible to this research team. The client service model was evaluated by an internal team of Vision Australia personnel in the fall of 2006. The purpose of the evaluation, the methods used to assess the service model, and the findings of that assessment were all unknown to this group. Accessing and analyzing this literature shed light on the service model evaluation techniques that Vision Australia does (or does not) not want to explore further. In addition, the service models of the Royal Blind Society, the Royal Victorian Institute for the Blind, and the Vision Australia Foundation were archived internally with Vision Australia. These data were analyzed throughout the course of the project, the exact epoch of which is detailed in Figure 3.

While understanding the tools with which the models are evaluated was necessary, strategies, structure, and content of the service model evaluation modules were explored as well. When certain techniques were found to be advantageous if incorporated into the current evaluation model of VA, a given model was explored further to provide understanding in what ought to be targeted in VA's model. The most important factor in examining other organizations was the comparison between what they offered and executed in terms of client services and service evaluation in comparison to the needs of Vision Australia.

4 Service Model Evaluation

The first deliverable of the project centered on the new client service model of VA and its overall implementation. To determine the extent of implementation, the key aspects of the model, and methods for overall evaluation, the project team focused on interviews with regional personnel and managers. The frameworks for the pre-merger organizations' service models were analyzed and compared to the new VA service model. Additionally, methods were evaluated for understanding when successful implementations have been reached.

4.1 Archival service models

In order to fully understand the implementation of the new client service model, the service models of the pre-merger organizations were acquired and analyzed. The service models that were obtained were from the archives of RBS, VAF, and RVIB. These pre-merger service models were analyzed in addition to the new VA client service model.

4.1.1 Vision Australia Foundation service model

The VAF organization, based in Victoria, focused its attention not only on the provision of services to individuals having vision loss but also in the creation of homes where these individuals could stay. VAF actively fought against injustices held against individuals in the blind and low-vision communities. VAF focused its attention on adult clientele more so than children.

Prior to the establishment of VAF in 1998, the organization was known as the AFTB or the Association for the Blind. The Vision Australia Foundation service model was analyzed on two levels. The first was the service model as it was documented before the VA merger and the second was prior to the founding of the Vision Australia Foundation. The two documents were obtained from the Geelong office and seemed to indicate very little difference from one model to the other.

4.1.1.1 The service model framework

The Vision Australia Foundation service model was based around three areas of service provision. These were Primary Services, Skills Services, and Support Services. Each of these main areas of service provision was then individualized for the client through six specific service programs: Assessment, Individual Support, Sensory Adjustment, Life Skills, Center Support, and Community Support. Interviews with ex-VAF staff revealed that each of these service programs was closely related to the specialist that would provide the services.

For example, the assessment portion of the pathway was conducted by a multi-skill team member whereas life skills would be a program conducted with an OT. In the service model document VAF rigidly structured steps by which the organization was to help a client meet the goals of overcoming fear, regaining life skills, regenerating self esteem, and reestablishing contacts in the community. When the client entered the VAF system either by referral or direct contact, he or she established contact with one service provider who could have any capacity within the organization from OT to O&M. These service providers were thus referred to as members of the multi-skilled team. This provider and the client then decided which of the three areas of service was most important to begin with or in what order to follow through on all of them (Vision Australia Foundation, 1998).

Fear was observed by the organization to be an emotional response to any loss of vision especially if the individual lost vision over time. The goal of VAF was to provide to their clients immediate support through a personal relationship should the client want to discuss the conditions or specific fears that they may have had as well as offering the most current information concerning the specific eye conditions so that the clients were as informed as possible.

Loss of life skills occurred when the individual with vision loss felt incapable of doing any task on a daily basis not necessarily because of physical limitations but also from misinformation regarding his or her condition. To combat this, the main objectives of the VAF organization were to provide information about eye conditions and their effects as well as to teach individuals how to perform daily tasks with their visual limitations.

The VAF organization also recognized that individuals with vision loss tend to lose self-esteem mainly because they feel worse about themselves and their loss of independence. The organization set goals for their clients and their staff to regain the client's self-esteem by setting reasonable goals that could be attained and recognized.

Finally, the VAF organization recognized that with vision loss came a sense of isolation for the clients. They felt less confident in their independence outside their homes and in their abilities to perform daily tasks on their own. This then tended to limit their involvement in the community and contributed to the feelings of fear and loss of self esteem. To overcome this, the organization set out to work on confidence and independence in and out of the home as well as providing more information to the community for a widespread understanding. These goals were accomplished through counseling as well as OT and O&M training as those services allowed the individual to feel more independent in the home helping to bolster confidence.

The goal of Primary Services as outlined in the service model document was to overcome the client's fear associated with vision loss. This fear could be anything from fear of losing independence, to fear for safety, and fear of surroundings. To accomplish this goal the organization provided immediate support to the client with the provision of ample information and entrance into an immediate service pathway that the client could stay in for as long as necessary. The service programs provided were based on the level of fear and the areas of life being affected by it so that the client could receive the most from the experience. A predominant service in this sector would be the counseling specialists and psychologists who would try to develop a personal relationship from which to build upon throughout the pathway (Vision Australia Foundation, 1998).

The Skills Service sector of the model aimed at the regeneration of the lost life skills and also the regeneration of self-esteem as usually the loss of life skills led to a lessening in emotional state. The specialists in this area focus on providing visual aids and mobility skills to the clients. Through relearning these skills, the individual was thought by the organization to regenerate a sense of self worth and independence leading to an increase in self esteem.

The VAF organization also recognized that when clients lost their vision, they began to feel isolated since they felt less able to interact on their own outside of their homes. The Support Services sector was thus provided to help these clients reestablish ties within their community. The organization provided information to the local communities to promote awareness of vision loss and its implications. The services also aimed at supporting recreation and other involvements within the community so the client could become more social and included outside the home through activities such as Day Programs and outings. Additionally, programs aimed at bettering mobility and independence were incorporated into the service pathways.

As the VAF service model document was made to be a framework, an outcome was established for each of the three service areas. These outcomes were very broad and meant to pertain to every client entering the system. The differences between clients were the service pathways used to achieve the same broad outcomes. For Primary Services, the goal was to have the clients overcome any fears they had of their vision loss and their inability to perform daily tasks so that they would actively participate in the choice of their service pathway and advancement. For the Skills Services, the organization wanted clients to understand their individual visual conditions as well as know possibilities and limitations stemming from their visual conditions. In other words, VAF wanted their clients to understand situations where their vision loss would be a problem and where it was just something to be overcome with

training and visual aids. In addition, a goal the organization had for their clients was to become proficient in living skills such as cooking and have appropriate assistive devices if necessary. For Support Services the organization wanted the client to be able to independently access any information required as well as be able to participate to the extent they wished within their communities through recreation and socialization.

Based on these main goals surrounding the three service areas, the client and service provider identified smaller goals for each step of the service provision. These goals would include the expected final outcome of a given service, the length of service, and the length of the review period before the client would be contacted again. The client would then strive to achieve these specific goals by following the service pathway. Often these pathways were built upon one another with significant overlap between the three main areas of service and the six determined pathway goals. Incorporated into each of these service pathways were a number of different service specialists.

Each service center was comprised of individuals from different capacities within the organization. As the organization ran from a regionalized approach, meaning service centers offered more than one specialty to every client from only a single place, the workers were considered a team of that center. Each team had members proficient in social work or welfare services, orthoptics, assistive technology and information provision, occupational therapy, orientation and mobility, group facilitation, day programs, recreation services, and telephone support programs dependent upon what individual services the client needed to achieve their goals (Vision Australia Foundation, 1998). A visual representation of the service model can be found below in a stepwise manner as Figure 4.

Vision Australia Foundation Service Model
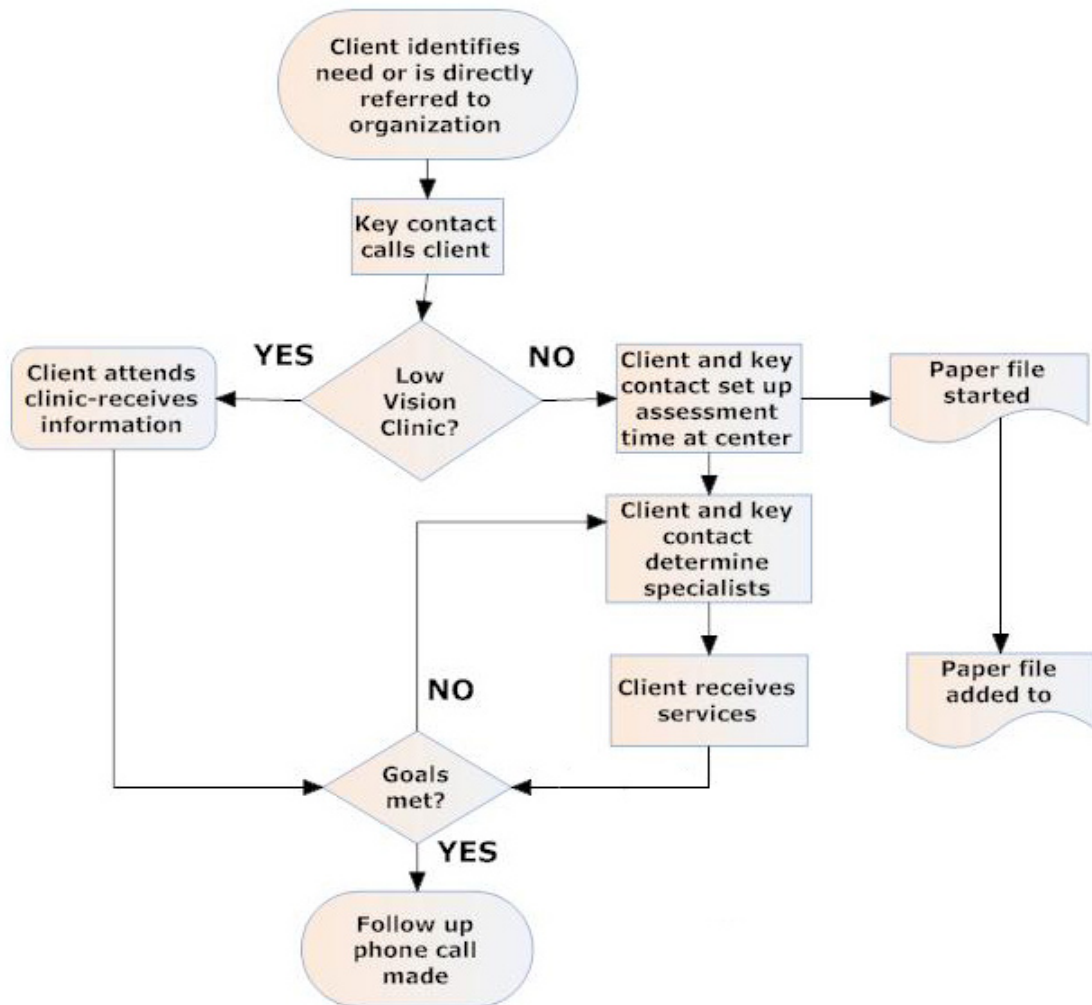
Figure 4- Vision Australia Foundation client service model flow chart

4.1.1.2 Client Intake

The VAF organization was made up of regionalized service centers having multi-skilled teams. This means that within each service center, dependent on size, there was the possibility of an OT, an O&M, an orthoptist among other specialties and even multiples of the same. In addition to serving the capacity of the specialist, there was also a possibility that these individuals served as the contact person for a new client.

A client in the VAF model would have been directly referred to the service center from a personal physician or eye specialist or could just have identified a need for visual aid and contacted the organization directly. At this point, the client would be paired with a contact person within the organization that was mentioned earlier as being any of the specialists within the center. The client and the contact would set up a time to meet either at the service center, over the phone, or in the home if necessary. At these meetings, the contact

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and the client would discuss any visual issues or hardships in daily life he or she was having. The first generalized goals were determined and the appropriate specialists selected.

Upon meeting with the specialists the client's goals would be further refined so that clear outcomes could be targeted. These goals as well as the goals made initially with the contact in the organization would be recorded in both the CIARR and the Service Pathway Proforma. These documents were meant to hold all information concerning the clients service pathway.

Every client in the ex-VAF organization would have had the same intake process. Whether it was the individual's choice to approach the organization or a direct referral from a health care provider, the client would have first been contacted by a chosen contact within the organization having any specialty background. From this contact and a follow up visit or phone call, the main goals the client had in mind would be discussed and recorded. It was also at this stage that the contact would suggest other help from outside sources such as a meals on wheels program or a financial counselor, if needed. Once the client passed the initial intake point, the actual service provision and pathways chosen varied.

4.1.1.3 Record keeping

As there were many goals for outcomes discussed between the client and the providers, proper documentation was also required by the client service model. A Home and Community Care (HACC) Client Information and Referral Record (CIARR) was made for each client when they entered the organization's system. This record kept basic information about the client and their vision loss as well as results of all assessments done throughout the service provision. In addition, all goals were to be recorded here by the service providers to track progress and identify any new areas of need as time passed.

In addition each client also had a Service Pathway Proforma which was a more specific log of goals and outcomes achieved. For each goal, the document records an outcome acceptable to the client as well as measures taken in order to achieve the goals that are acceptable to both client and service provision team. Individual products and services may be listed as well as the specialists necessary to complete the tasks.

4.1.1.4 Evaluation of outcomes

Throughout the Client Service Model documentation it was reiterated that the organization wanted to focus on final outcomes by "giving priority to effectiveness of outcome over efficiency of process" (Vision Australia Foundation, 1998). In other words, if the processes needed to achieve the final outcome were not simple for the organization, but in

the end the better result was obtained, that was viewed as a worthwhile investment by the organization.

To assess these outcomes, the predominant method of feedback was a follow up call placed to the client about three months after the end of service and was conducted by the "contact person" the client was associated with in the VAF system. The contact person would refer to the goals originally placed in the CIARR and the Service Pathway Proforma and discuss whether the client felt those goals had been attained and whether any future services could offer improvements. Unfortunately, the structure of these calls was not standardized and the attainment of the goals seemed to be based on an understanding between client and particular service provider. The SERVQUAL instrument was used to evaluate the services themselves as well as the final outcomes attained by clients. As has been discussed previously, the SERVQUAL instrument separates areas of service as well as outcomes based around activities and inquires first whether or not that particular activity is important to the client and secondly whether the goals they wanted to achieve were attained.

There was no mention of formal written survey methods or other evaluation assessment tools written in the documentation. Evaluation of outcomes was left to the subjectivity of the "contact person" and their evaluation (Vision Australia Foundation, 1998).

4.1.2 Royal Blind Society service model

The Royal Blind Society focused its attention on the states of New South Wales and the Australian Capital Territory at its founding. The organization provided services that helped individuals with vision loss integrate into traditional society as best they could. The services were therefore focused around mobility in and out of the home, learning aids, and use of current technologies as visual aids when appropriate.

The Royal Blind Society Service Model document was written as a framework more focused on the individual disciplines and goals created in that capacity rather than overlying purposes. As client numbers began to grow and awareness of the services offered by RBS became better known, the organization began to use its Vision Assist program more effectively in addition to the traditional service center involvement.   The services offered by RBS were clinic or center based. All training sessions, any specialty training, and any visual aid training was done at either the Vision Assist clinics or individual service centers. Home visits were only made to individuals who were home bound as the organization felt that was the best way to reach the most individuals in the shortest time span (Royal Blind Society).

4.1.2.1 The service model framework

The framework used by the RBS organization focused not on a defined pathway as VAF did but rather on the services being offered and available. The RBS service model implemented centralized service centers in addition to a program that was similar to the Day Programs of the VAF model called the Vision Assist clinic. The centralized service centers employed by the organization meant that the service centers were only made up of one specialty. For instance, all of the OTs in the RBS model would be accessible in one of the service centers. The client would contact the organization and determine which services were most needed and from there be directed to the appropriate service center. Upon establishing contact with the organization a client liaison unit would be assigned to the client. This person did not hold only the coordination role but also worked in a specialty like O&M or OT. This liaison would also inform the client of the available Vision Assist clinic that offered more specialists at the same time.

A Vision Assist clinic had optometrists, orthoptists, low vision advisors, and counselors present at each meeting. Prior to attending the clinic, each client was sent a questionnaire asking specific concerns the client was having. Based on the answers to these questions, and the individual assessments performed at the clinic, the appropriate specialists were determined for further training at the clinic. An optometrist sees clients who have not had an eye check in the past 18 months or whose prescriptions for visual aids have not been reassessed in 18 months time. A client would speak to an optometrist concerning any new exams needed and new visual aids available. An orthoptist consults with clients who have seen an optometrist for an evaluation of eyes or visual aids in the past 18 months as well as anyone who wants consultations on the appropriate and beneficial means to use light and any new visual aids available. Clients can consult with low-vision advisors concerning any new technologies and the best means by which to use any residual vision most effectively.

Each of these specialists conducted assessments on attending individuals. Using these assessments they suggested appropriate vision aids and training as well as made referrals to the specialty services such as OT and O&M. To have a better comprehension of what the clients wanted out of the interaction at the clinics, a questionnaire was sent out prior to the clinic date to every attending individual. The questionnaire was a series of very general questions concerning areas of difficulty both inside and outside the home, any emotional problems, as well as general independence questions. The organization made two surveys; one was made for adults and the other was made for school aged children. Both questionnaires can be found in Appendix L (Royal Blind Society).

If a client attended the Vision Assist clinic and needed further assistance, they were referred to a service center having the appropriate specialist. At this instance there was also a questionnaire much like that sent to attendees of the clinic that was filled out prior to the client arriving at the service center. This questionnaire was then used by to further discuss the overlying issues due to the visual impairment so that a service pathway can be defined.

In the document that was analyzed, there were no structured purposes or goals established by the organization on the whole. Instead, the client and the specialists they worked with discussed what objectives were the most important and created necessary pathways accordingly. In this model, it was also possible to reenter the service provision step should new needs be established or further assistance be required. A visual representation of the client service model can be seen in Figure 5.

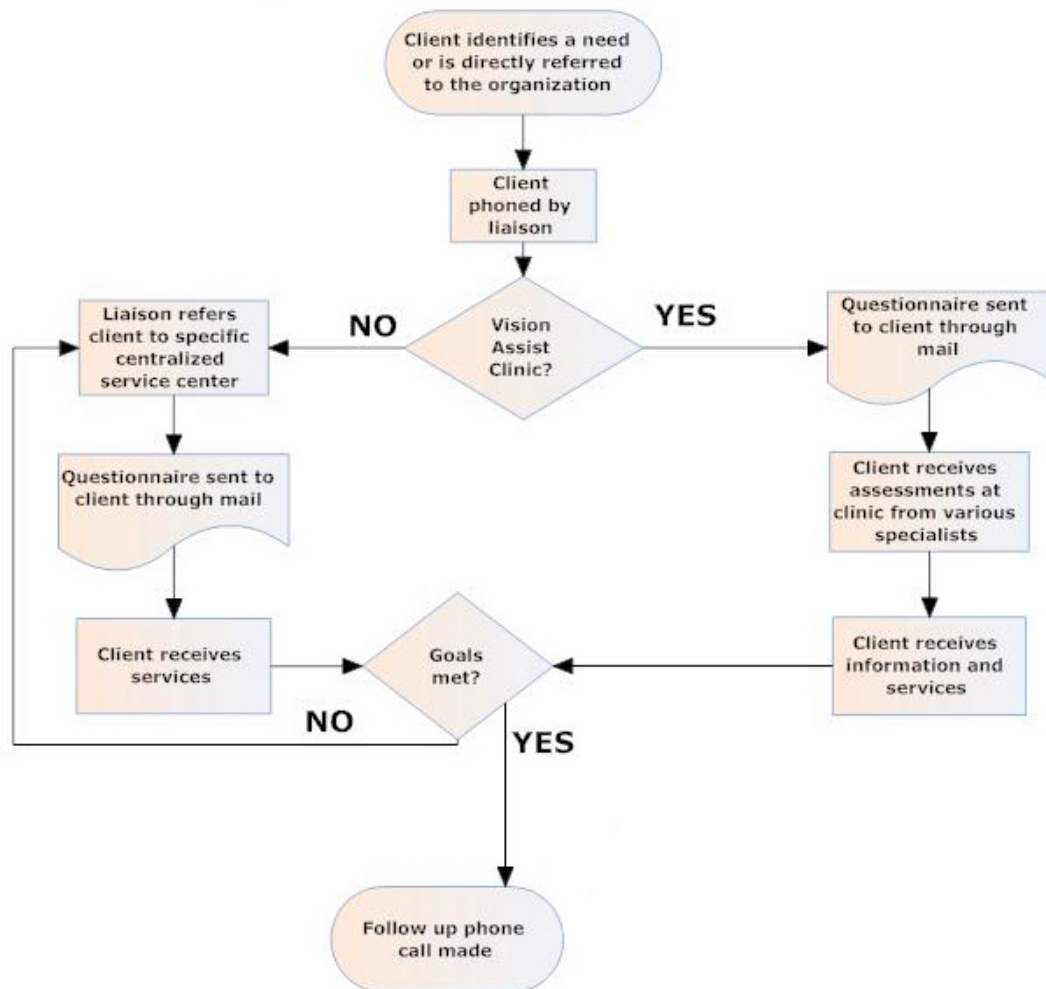**Figure 5- Royal Blind Society Client Service Model Flow Chart**

4.1.2.2 Client intake

If the client identified a need for visual assistance they were able to contact the main RBS office to begin intake steps. If a formal referral was made on behalf of the client through a medical professional, that individual contacted the organization and described the purpose for the referral.

From this point, the organization assigned a contact person from within the organization to then contact the new client. This contact person had no specific specialty background but could hold any number of positions within the organization. He/she would call the client and discuss a time to clarify objectives and needs between the contact person and the client so as to determine the best service pathway the organization could offer. If possible, the contact person would also attempt to determine if the client could first attend a Vision Assist clinic. At these clinics questions could be answered fully and visual aids would be available from multiple specialties at the same time. If it was determined from the initial contact that the client could be seen at the Vision Assist clinic, the contact person would forward the appropriate questionnaire dependent on age so the client could have it filled out for the visit.

If during the first phone meeting between the client and the contact person, it was determined that a Vision Assist clinic was not appropriate for the client, the focus would turn to the client's goals. The client would discuss in great depth exactly what was difficult in daily life and how they wanted to improve upon it with RBS help. The contact person would keep detailed notes to integrate into the client's file concerning these needs and main goals for later use.

After discussing the main goals, the client and the contact person would determine the most important specialties to become involved with as well as any outside sources of help. The contact person would document which specialists were of interest in the file as well as providing or sending the questionnaire to the client so that at the first specialist meeting, the document would be filled out. The client was also referred and directed to the appropriate service center as the RBS organization had centralized offices and the specialists were not all in the same location. The service centers in the RBS organization did not have multi-skilled team. Rather, all OTs of the organization were found in one service center while all the orthoptists were found in another service center. In order to receive different services from many specialists in the RBS model, a client would have to go to several different service centers.

4.1.2.3 Record keeping

The document analyzed concerning the RBS service model included no mention of specific record keeping procedures. All that was stated in a client record was the basic information gathered from the client as well as specific details of services received. To better understand the practices, record keeping became a main question during interviews.

It was determined that contacts and specialists derived much of the information they required from direct communication with the client. At the Vision Assist clinics or when the specialist met with the client, a questionnaire had already been filled out by the client. This questionnaire included questions about daily activities that were difficult, areas of interest to the client, and other general questions the discussion was able to build from. Any notes, goals, or points of interest were written in the client's paper bound file as well as input into an electronic base if one was present at the service center.

The specific information that was written concerning the client was not standardized by the RBS organization. Instead it was left up to the individual contact persons and the specialists to maintain their notes as they saw fit. Ideally, everyone was to take detailed notes of progress and attainment of goals but there was no form or documentation method known to the employees interviewed that was standard across the specialties and the organization.

4.1.2.4 Evaluation of outcomes

The RBS service model included a few methods by which to assess outcomes. The frequently used method was a follow up phone call between the client and their client liaison unit but surveys and focus groups were also conducted. In each instance there was a possibility for qualitative data intake as well as traditional quantitative results. The questions varied based on who was conducting the survey or focus group and even the follow up phone calls and as a result the information received was not standardized across the organization.

Follow up phone calls were placed through the client liaison unit, who could be a service coordinator or other specialist depending on the particular client, about four weeks following the conclusion of service provision whether that service was with a specialist or through Vision Assist clinics. These calls traditionally recapped whether any new goals had been developed that required additional services, whether the client was satisfied with the services, and whether the client had any further questions to ask of the organization.

Yearly surveys were sent to a representative sample of clients. The yearly surveys also attempted to gauge client satisfaction as well as quality of the services.

Finally, quality consumer meetings or focus groups were held throughout the year. Clients provided feedback in regards to specific services and products offered by the organization. This feedback was used to optimize the available products and services so that they would be of the best use to the clients (Royal Blind Society).

Through interviews with various former RBS service provision staff and managers it was also determined that in the past there was an outcomes assessment aimed at determining client satisfaction as well as equipment satisfaction. The assessment was administered at the end of service provision and asked the client to answer questions concerning successes and failures with the services they received, overall satisfaction with services and atmosphere, any questions or comments about equipment they used, and overall views they had concerning their final outcome. The reason this assessment was discontinued was the issue of accountability. The surveys were paper documented and as a result many clients unable to read even large print were not capable of filling the assessment out independently. A carer or friend often times had to assist which could have led to errors or bias from misunderstandings. The surveys also predominantly focused on individual services and not overall goals such as independence and mobility, limiting the evaluation possibilities by the organization.

4.1.3 Royal Victorian Institute for the Blind service model

The Royal Victorian Institute for the Blind offered its services within the state of Victoria at its inception. Besides the main focus of provision of services and products helpful to integration into society, RVIB focused on the education field as well. The organization realized that products such as books in Braille were not available to students with vision loss making it harder for the student to be successful at school. RVIB offered the first Braille libraries and focused more attention on children of school age as well as adults.

The RVIB service model was analyzed for the same points as the VAF and RBS models. An inherent difference was that the RVIB organization was more home-based than center-based. Though the RVIB service centers were staffed by multi-skilled teams, the specialists met clients in their home unless otherwise advised. There were additionally low-vision clinics that served much the same capacity as the Vision Assist program

4.1.3.1 The service model framework

The RVIB service model was not obtained as a document since the merger led to an expulsion of the past documentation by the service centers. In order to fill this gap, interviews were conducted with as many ex-RVIB employees as possible to determine the overall framework followed by the organization.

The RVIB organization wanted to focus on the needs of the client as well as the learning environment they were surrounded by. For this reason, the home-based approach was employed by all specialties as long as the client wanted visitors to their home and the setting was feasible. The main objectives of the organization were dependent on the age of the client and were very broad objectives that the client and the service provision staff could build upon.

For young children the organization wanted to be able to provide all tools and skills necessary for successful matriculation into school. For adults, the organization wanted to help in areas of self-esteem and understanding as well as the general concepts of independence and mobility within and outside of the home.

Every client when they first contacted the organization or who were referred would be contacted by a service coordinator whose specialty was determining appropriate specialists to have consultations with and following a case from its opening to its closing. From the first contact between client and service coordinator which took place either in the home or over the phone, general ideas were established for main goals. These goals were then built upon with the individual specialists at the first meetings so that client and service provider could fully understand each other and comprehend all possibilities. All information was documented in the client's electronic file so that every specialist as well as the service coordinator would be able to determine what services each client had received and the effects of that service.

Throughout service provision, be it long term or short term, the service coordinator and the client could reevaluate the given situation to see if the goals were still appropriate and alter the service pathway being followed. A client could receive services for as long as was necessary and a case could always be reopened should new needs arise. A visual representation of the framework can be found in Figure 6.

Royal Victorian Institute for the Blind Service Model
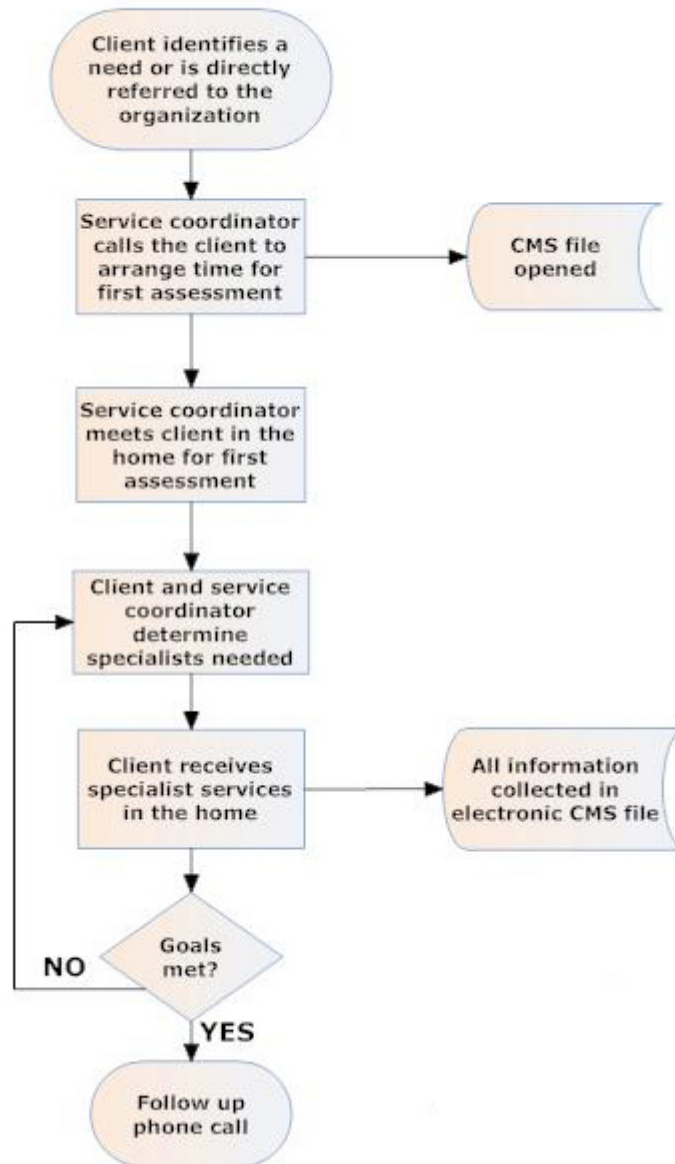
Figure 6- Royal Victorian Institute for the Blind Client Service Model Flow Chart

4.1.3.2 Client Intake

Clients were introduced into the RVIB model either through their own identification of needs or through formal referrals from outside sources such as ophthalmologists. When the client arrived at the service center, specific details concerning problems in daily life and any specific goals were documented by the intake person into the electronic file referred to as the Client Management System (CMS).

Using this basic information, the service coordinator would then follow up with the client by calling them within the week to set up a meeting time for the formal assessment. This first meeting would take place in the client's home. During the meeting the first

assessment took place and centered on generalized goals the client had. Based on these goals, the service coordinator would make appropriate referrals to the necessary specialists. It was also at these meetings that the first plan of action was created. The goals or objectives that the client and the service coordinator determined were described in a written document outlining the agreed upon services and specialists. After the writing of the document the client actually signed the plan.

All of the information gathered by the service coordinator at the first evaluation was recorded in the CMS and then accessed again by the specialist taking up the case. Using this information, the specialist would clarify goals with the client at the first specialist-client meeting. These meetings also took place in the client's home unless the client chose differently as the RVIB model stressed the importance of learning specialty works like those of OT and O&M in an environment where the client was comfortable.

Information regarding goals the client sets for themselves, progress, and new concerns were documented in the CMS for later use and referencing. Following the conclusion of service provision or every 6 months should the service have been ongoing, the service coordinator would conduct a follow up phone call. During these phone calls, the service coordinator would ask the client general questions regarding their overall satisfaction, whether any original goals were not met, and whether any further services were needed. Should new services be needed, the service coordinator would refer the client to the appropriate specialist and the process would repeat. If no services were needed, the service coordinator would document all information available to include any outcomes information in the CMS and then close the case.

A case in the RVIB model could always be reopened should the client identify new needs or have any future referrals for service. All information concerning the client and services received was electronically kept in the CMS so that the file would be readily available should the case ever be reopened.

4.1.3.3 Record Keeping

So as to avoid loss of information and confusion between service providers, the RVIB model relied heavily on electronic documentation of all information concerning a client. When a client first contacted the organization or was contacted by a service coordinator from the organization, the basic information was input into the CSM on the computers and acted as the client's file throughout all service provision.

The CMS was an electronic system available to all members of the multi-specialty RVIB service team. The system held areas for the documentation of basic client information such as name and date of intake, identification of needs, and any notes added by the service coordinator and specialists during service provision. There was also an area of drop down boxes associated with general client outcomes assessments that were filled in by the service coordinator at the end of service provision as well as each service provider following the end of interaction. The information gathered for this was concerning overall satisfaction, whether or not all goals had been met and if not the reasons for the failures, as well as any concerns the client had with either the organization or the overall service provision.

During every assessment, whether it was with the service coordinator or with individual specialists, notes were taken in paper format by specialists concerning general feelings the client had towards the interaction, any goals or objectives to complete, and overall progress. These notes would later be added to the CSM file so that all information would be available and in a central place for later use.

Specifically, there were screens within the CSM file that were specifically for notes, goals, and satisfaction so that the information was kept in an organized manner and easy to access. When a client completed service the CSM file also required electronic input of information concerning the reason for termination of services as well as any general notes from the client or the service provision personnel.

4.1.3.4 Evaluation of outcomes

The RVIB model did not have an outcomes assessment tool that any of the interviewed employees could recall. It was instead done on an individual basis between the client and the service staff. After each service, whether with an OT or an orthoptist, the question of satisfaction was posed to the client and any answers given were documented in the CSM file. The service coordinator would also make a follow up phone call about one month or so following the end of service to determine a more generalized idea of satisfaction and outcomes.

In the CSM file, there were drop down boxes that the service coordinator or specialist could mark answers to questions concerning outcomes and overall satisfaction. These questions were very limited, however, and consisted of concepts such as "Were your goals met?", "Where there any disappointments?" without having any place for explanations.

It was also determined that surveying of clients occurred randomly but not by the specialists that had provided services to the selected clients. It was done anonymously from

other individuals within the organization and for the purpose of determining whether the service providers were beneficial to the clients or if there were areas of concern.

4.1.4 Vision Australia client service model

The new Vision Australia client service model document was designed through a collaborative effort of representatives from the three pre-merger organizations. Its aim was to bring the best possible services to all clients regardless of their geographic location or pre-merger organization affiliation. The document is a summary of possibilities open to Vision Australia. It is not a guideline but a compilation of goals and suggested ways to achieve those goals. The service model is designed to be a comprehensive service delivery framework to ensure that clients stay active and independent within their communities as much as they choose. It focuses on the effect provided services have on the client and the client's life as a whole. The model is being implemented currently, and it is still in the process of being further developed by the senior managers as it is implemented.

4.1.4.1 Service model framework

The service framework is designed around seven main goals. The first goal is availability of information, meaning the client is to receive all the information they need to make informed decisions about available services and their vision impairment in general. The second main goal of the service model is emotional support for the client. It is sometimes the case that clients dealing with a newly acquired vision impairment may need to learn to cope with their impairment before they are willing or ready to begin services. These services may present challenges associated with their vision impairment and they must be ready to face those challenges.

The third goal is independence in the home, followed by independence in the community. These two goals are perhaps the most vocalized by clients, and are very important to the success of Vision Australia's services. If a client does not have increased independence after the service provision has ended, then in most cases, the client will still not be able to live their life the way they want to. Clients often want to be useful parts of their community and household, which often makes independence necessary.

Education is the fifth goal of the client service model. Knowledge about vision impairments is the key to understanding between members of the community that do not have a vision impairment, and those that do have a vision impairment. It can also make a big difference in what clients expect from themselves and from their services. Employment is another main goal of the service model. Many clients are looking for ways to either keep

gainful employment, or obtain gainful employment. Communication tools is the seventh and final main goal of the service model. It is important that clients have many avenues of communication with Vision Australia and their world in general.

The client service model is broken into several functional steps that clients as well as service providers follow. The first step is the initial contact with the organization. This can be done in person or over the phone through the National Contact Center. The next step is that the client's individual needs are assessed by the key contact, based on one of three different view points, namely one-off non-complex service contact, preliminary screening and specialized assessment. Based on that assessment, the service planning and coordination takes place. This determines what service pathway the client will follow and what goals the client wants to achieve. Emphasis is placed on the fact that the client has control over what services are provided to them. Once the service pathway is determined, the duration, intensity and extent of the service is decided upon. Again, these are determined primarily by the client with the assistance of the key contact person. Once all of those things are planned, the service provision begins.

Individual, specialist service provision personnel provide each type of service such as orientation and mobility and occupational therapy. In addition to these services, Vision Australia seeks to provide services for children and young people, education, training and employment, recreation and social interaction, independent living solutions, equipment solutions, low vision services, deafblind services, counseling services, information for community education and awareness, and library and information services. All of these services are available to all clients of Vision Australia based on the pathways identified by the key contact and the client.

Once service provision is in place, the client's progress is monitored by the key contact in order to determine what changes may need to be made, if any. Also, the client's goals are reviewed and updated based on their progress in the service pathway. After this step, the service pathway is continued to completion, and follow up is done with the client by the key contact. In some cases, the client has completed the planned service path, but requires further training or other services. This is most common in children growing up with a vision impairment. In this case, their service provision may never really end until adulthood, yet their needs change as they grow older. Clients with these needs may re-enter the service planning and coordination phase and continue with further services. The visual representation of the client service framework can be found in Figure 7 below.

Vision Australia Service Model
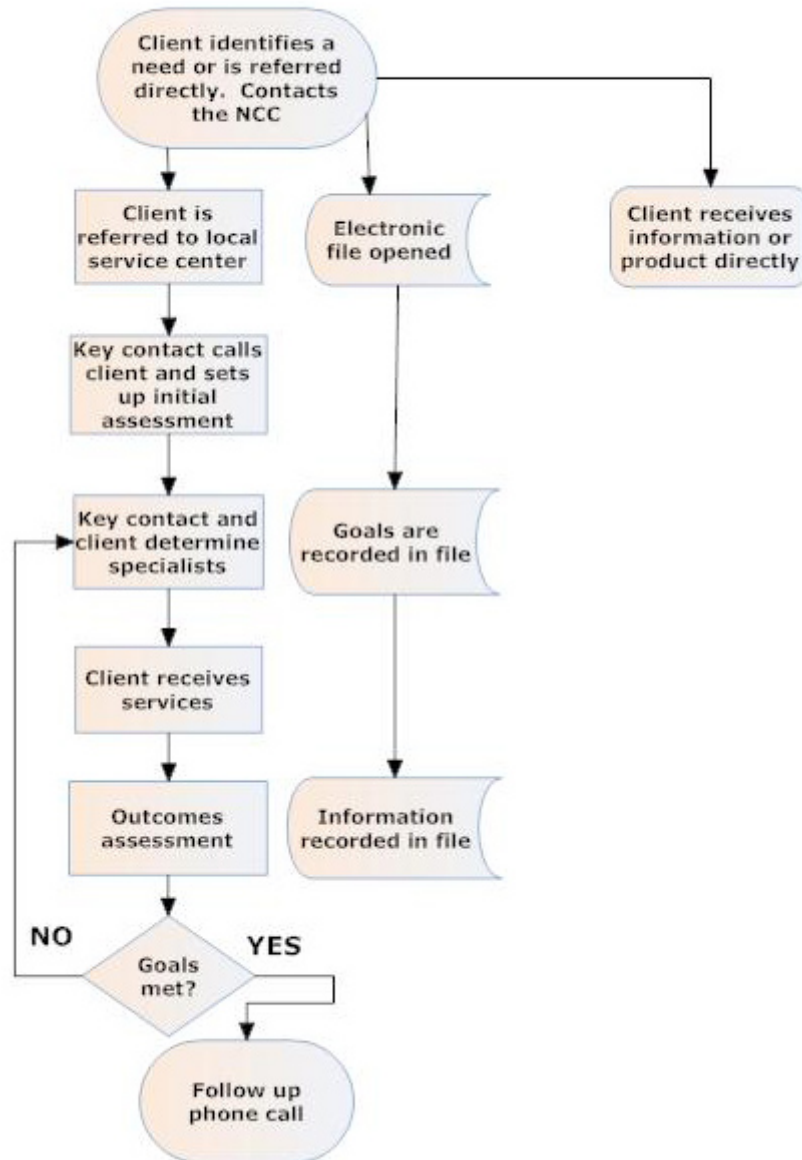
Figure 7- Vision Australia Client Service Model Flow Chart

4.1.4.2 Client Intake

The first point of contact to the organization is not always the same for all clients as some are directly referred and others contact the organization from self-made assessments, but Vision Australia wishes to ensure that clients contacting the organization using the 1300 number can be directed to the correct service center. Using a National Contact Center (NCC), clients from across Australia are to be able to ring one number and be transferred to whatever service center is most geographically appropriate. Generic service calls to local sites must be transferable to the NCC as necessary.

Clients should be assigned to a key contact person when they are first taken into service. This person must be trained in service coordination according to Vision Australia's core competency training. These key contacts must be familiar with the clients needs such that service planning can begin. Service determination and coordination should be interactive with the client.

After assigning a key contact person to the client, the key contact should determine the first meeting time. At this meeting, the initial pre-assessment should take place and should center around quality of life issues. Using this pre-assessment, it is more likely that appropriate specialists could be determined and goals more accurately defined.

4.1.4.3 Record Keeping

Vision Australia seeks to standardize the record keeping process within the organization. A clear shift from paper-based record keeping to electronic record keeping is indicated in the new service model.

An electronic database called the Client Management System (CMS) is to be used by all staff to record all client information including assessments. Staff should be familiar with the system and proficient in its use. This is an extremely important part of the new client service model because it strongly promotes standardization of processes and record keeping.

Another requirement of the new service model is that all Vision Australia staff must have the ability to encrypt and transfer all client information including client records. Also, Vision Australia requires that a universal client assessment tool be in place and electronically integrated into the new database.

4.1.4.4 Evaluation of outcomes

The new service model discusses only the assessment of organizational outcomes; things such as monitoring service usage trends, looking at key issues affecting service provision capacity, and identifying ways to improve the quality and relevance of core service delivery and implementing those improvements. Additionally, developing a link between all areas of the organization such that developments are made with an organization-wide approach is mentioned. Another planned aspect of the organizational assessments is to provide insight into future resource allocation for client services and to review and measure the contribution of peers on the provision of core services. Finally the document indicates that Vision Australia needs to assess the progress of the Client Service Department's model implementation plan. These things are not specifically related to the assessment of client

outcomes, but they all contribute to the organization's ability to deliver quality services to the clients in a timely and efficient manner.

4.2 Implementation of the Vision Australia service model

The new Vision Australia service model has yet to be fully implemented by any of the service centers in Victoria, New South Wales, the Australian Capital Territory, or Queensland. The service model is not a completely unique document but rather a compilation of the service models previously utilized by the three pre-merger organizations.

In order for successful implementation to occur, Vision Australia's goals for the implementation of the new service model must first be discerned. Additionally, it is beneficial to identify benchmarks that can be used to measure progress towards implementation of the model. These benchmarks must not only indicate changes in service delivery but must also be feasible to measure.

4.2.1 Important aspects of the new service model

The new VA service model was analyzed in order to determine exactly what the organization wanted to implement across the areas of service as well as how this expectation differed from the service delivery goals and mechanisms of the original pre-merger organizations. In order to correctly evaluate an implementation on any level, it is first imperative to understand what is being implemented, why it is being implemented, and how that will affect the overall organization and its employees and clients.

The important points of the new service model as was discovered through interviews with management and service personnel were numerous. The first point of interest was the themes that the organization wanted to focus on in terms of services provided. The document outlined seven clear themes where quality outcomes were to be assessed.

The overall structure of the organization was also found to differ from the structures of the three pre-merger organizations. The proposed new structure is intended to make intake and continued service provision within the organization a standardized process allowing all clients access to the best possible services while keeping adequate levels of staff and within budget. Specifically, the service model document called for a uniform intake process that would allow every client equal access to all services provided by the organization. The document also called for a unified record keeping process allowing client information to be readily available and maintained. Finally, the document stressed the importance of expanding services organization wide.

Finally, it was observed in the service model document that communication between client and the organization was going to take a new direction. Each client was to have one contact person within VA that followed the entirety of the case from start to finish and who would act as that client's liaison to the organization.

4.2.1.1 Themes of service

The VA organization in addition to the pre-merger organizations all focused their service provision around themes or overlying goals. These themes, though often similar, were not identical between the four service model documents. The themes varied not only on content but also in how they impacted the service pathway. The VAF model had very clear objectives and themes. RBS focused on individual tasks more than broad quality of life issues. The RVIB model followed a similar theme structure to RBS but focused on a different clientele base.

The VAF model had three structured themes. These were Primary Services, Skill Services, and Support Services. The three themes all had very broad and general qualitative outcomes for the clients. VAF reached these goals by making smaller and more manageable goals among six service programs. The specialists of the organization worked with the client through the service programs and ultimately accomplished the qualitative goals.

The RBS model was less focused on broad goals and more concerned with the goals of the individual specialties. The service model document that was analyzed was not in a written format structured from the beginning of service to the closing of the case as the VAF model was. It was instead written piecewise for each of the specialties. In the RBS model, the themes were directly related to the services offered by the organization. For instance, successful matriculation into kinder would be a goal for those specialists working with children. As compared to the VAF model and the new VA model, the RBS model was far less specific in terms of broad goal setting but more specific in terms of individual goals to accomplish with the specialists.

The themes of the RVIB model were much like the RBS model because broad themes were not specifically discussed. Instead the focus was on the interaction between specialist and client. As with the RBS model the specific themes of the model were not distinctly recognized but instead tied in with the offered services. For example, RVIB did not outline independence as a main goal to be accomplished with the use of all the specialists available. Instead the organization offered services such as O&M mobility training and cooking safety

that accomplish smaller task-based goals; these smaller goals do lend themselves toward a broader goal but without having been specifically decided by the client.

The new VA service model presents seven themes: information, emotional support, independence at home, independence in the community, education, employment, communication tools. The structural presentation of those themes followed much the same outline as the VAF model. The themes of information, independence in the home, and the like are very broad generalizations that are defined expressly in the document. As with the VAF model, the broad themes such as independence in the home are not accomplished by a single specialist but rather by a team of professionals.

4.2.1.2 Client intake and record keeping

During interviews senior management were asked to identify the most important aspects of the service model. Though answers sometimes differed from person to person, one aspect that remained constant was client intake. When asked to expand upon the concept, the managers remarked that the means by which every client enters the VA organization is not currently a uniform process. The service model document outlines a direct pathway for the intake process as well as for the recording of all client information.

It was observed that based upon the pre-merger affiliation of any given service center, there was a different method for client intake. Senior managers and staff agreed that the method of client intake needs to be uniform before any success can be reached with further implementation of the new model.

The new service model begins client intake when the client is either referred to the organization or after he or she contacts the organization directly. The NCC would handle the initial contact and refer potential clients to the appropriate local branch for further assessment and service provision. At the local branch, an electronic record begun by the NCC would be further developed with the service coordinator or key contact dependent upon the particular service center reached. This record would then be used for the duration of the client's services and would contain any and all notes and discussion of goals and outcomes the client had with the key contact and each service provider.

Currently, the NCC has not been established. This has made transferring clients to local centers more difficult. Once received by a service center, the intake process was found to vary based on the center. The service center offices continue to use the methods of their pre-merger affiliation. A difference was also observed in the manner that client files were kept. The new VA model states that every service center and staff member is required to

keep client files electronically using the CMS program. However, this has not been implemented. The RVIB centers have already become accustomed to the program and use it but they do not fill out all areas of interest, for instance the outcomes portion, to the same degree. The VAF and RBS centers do not use the electronic program and instead maintain a paper file for each client. Paper files add to the possibility of loss and make it more difficult for multiple specialists to review the same file and document goals and services in the same manner.

4.2.1.3 Interaction within service pathways

The new service model calls for an expansion of services to a larger client base regardless of geographic location. Another goal of the new service model is to create an understanding between the different specialists that the final outcome the client works for is not accomplished by one specialist's help but rather a full multi-skilled team and as such, the specialists and client need to act as a cohesive unit.

Centralized vs. regionalized service centers made a large difference in the ability of service provision staff to communicate effectively. The RBS model had centralized service centers. This means that in one center, there would only be members of the same specialty. For instance, in one service center there may only have been orthoptists. In another center there may only have been OTs. Because of this, and the fact that RBS used paper files, it was more difficult for the various service personnel to determine the full extent of a client's service pathway. The individual specialists would not have the opportunity to review the other professional interactions and to discuss with the client the impact of more than just one service provider.

RVIB, though a regionalized pre-merger organization, conducted all training sessions in the client's home. This meant that the personnel spent time not only doing training sessions but also commuting. Because of this transit, many of the specialists do not overlap time in the service center office thus limiting time for multi-skilled team analysis of a client's progress. RVIB had an electronic client file but few specialists filled out the file in the same manner making it more difficult for conclusions about general quality of life and tasks from other specialists to be drawn.

The new service model also depicts that the client's long term and broad goals, for example independence, should be recognized by all specialists beyond the scope of one specialty's contribution. To do this, the model recognized and stressed the importance of a

unified client intake procedure but also introduced the concept of more thorough initial assessments.

The management especially wants to see the service provision personnel discuss goals beyond just tasks with the client at the first meeting. For example, an OT should not discuss only tasks such as ability to cook and how to mark telephones. They should instead discuss with the client the quality of life concepts and how the OT services will fit into these broader goals of the client. Then, using this more thorough knowledge, an electronic record should be kept that is clear to all other specialists. Ultimately, this method of communication is for the better of the client in that services will be tailored to the broader goals and not just the task-based.

Ideally, all specialists associated with the same client should have direct contact with one another. By allowing specialists to talk in a team format, the smaller task-oriented goals clients make with the individual specialists can be viewed as they affect the client's main broad goal. Specialists would be able to discuss any options for the client and ultimately be able to provide the best services in the client's interest.

4.2.1.4 Contact between client and organization

Throughout the new VA service model document the concept of the Key Contact was established. The purpose of this individual is to serve as a liaison between the client and the organization. The need for a Key Contact person was based on reports from clients who felt that they were always talking to someone new when they phoned. The model for the Key Contact was based on precursors in the pre-merger organizations. The RVIB model had what was termed a service coordinator who only worked with service coordination. Service coordinators were not responsible for providing specialty services. The VAF model and the RBS model had service liaisons that performed two functions. The first was providing specialty services with backgrounds in O&M and OT, and other specialties. Additionally, they would provide service coordination for any number of assigned clients.

The management wants this particular feature of the service model to be implemented as quickly as possible because it has been specifically requested from the clients. The challenge in its implementation is in the training of the individuals and the decision of which model to follow. Through an interview with a senior manager it was determined that the service coordinator concept used by ex-RVIB offices would be best used in the larger service centers whereas in smaller service centers the method of staff being both a specialist and a contact would be best. Because both are acceptable methods by which to implement the

same overall concept, the concern is training staff in each service center to use the key contact effectively or training the staff themselves to be effective contacts.

4.3 Implementation evaluation deliverable

Vision Australia provided ample information concerning the new service model, documentation of the pre-merger organizations, and information received through interviews. Using this information, recommendations could be made to the organization concerning methods by which to evaluate the implementation of the new service model.

In order for the recommendations to be useful to the organization, the pre-merger organizations had to be compared to the new service model in terms of structure and purpose. The main focus of the model had to be established as well. It was determined that most likely the best way to determine overall success of the implementation was to identify key benchmarking indicators that could be used to measure the progress of the implementation. It was determined that if three areas were successfully implemented, the rest of the model would be easier to implement successfully. These areas of interest were Intake, Record keeping, and Communication. These are not the only important factors, however. Things such as appropriate training, appropriate use of feedback from the clients, and expansion are also important to the organization but will fall into place later on in the implementation.

4.3.1 Client intake procedures

After interviewing the general manager, it was clarified that the intake procedure for VA had not been implemented. Ultimately, there will be one national contact center or NCC that receives all phone calls to the VA organization. From this office the future clients will briefly discuss what they hope to gain from interaction with the organization as well as where they are geographically located. The NCC will then gather basic client information and forward the starting file to the appropriate local service center where service coordinators or the key contact would begin the service provision path.

The NCC is meant to standardize client intake regardless of geographical area or client needs so that all information is gathered and forwarded to the appropriate center in a timely manner. The electronic file system will also be initiated by the NCC.

This uniform process of client intake is vital to the success of the entire new service model. If the client intake process is done uniformly across the organization, smaller details will be easier to overlay. Establishment of the NCC by VA and overall client intake implementation is therefore important.

Obviously, once the NCC is established client intake should become more uniform as all calls will be directed to one center for all basic questions and referrals. The NCC should periodically reassess whether or not the calls are being transferred appropriately and the case files established with pertinent information. To perform this function, the NCC should have monthly reviews of the intake files begun and place calls to managers in the service centers to determine that the numbers of clients are still correct and relevant. To ease the establishment of the new intake method, it would be pertinent to distribute information across the organization concerning the plan for the NCC, how files will be initiated, and what VA expects for client intake procedures after the specific service centers receive the referrals.

In the instance when clients contact the local service centers directly, the number for the NCC should be readily available. Additionally, the local service centers should have the ability to directly transfer calls to the NCC so that the appropriate centers are reached. To gauge the implementation of these procedures, local management should be periodically asked to verify the ability to transfer calls as well as the presence of the NCC number and information.

Overall, there are several measurable indications of uniform client intake. These measures, once implemented, would indicate a success in the implementation of the new model in terms of client intake and are thus described:

- The National Contact Center is established
- The local service centers have the ability to transfer calls to the NCC
- The NCC number is available on the organization's public documents
- NCC personnel verify numbers of client's entering organization through NCC as compared to local service centers
- Information distributed concerning NCC purpose, appropriate electronic filing system, and establishing a key contact once the file is received

4.3.2 Record keeping and data collection

During interviews, specialists and management were asked how and what was documented in a client's file. Overall, no service center kept information in the same way or even asked the same questions regardless of the pre-merger affiliation. The three pre-merger organizations all had their own methods by which to keep and add to client files.

RVIB used electronic filing systems to record all information concerning assessments, goals, and outcomes. However, dependent on the staff member, the information actually documented varied. Staff was allowed to track information any way they chose so long as

the file could be filled out for the organization concerning services, outcomes, goals, and all relevant information. Some staff members of various specialties chose to create their own assessment rubric while others took notes during the assessments and service meeting.

RBS and VAF used a combination of paper file systems and electronic files in some areas making it impossible to accurately assess whether or not the entire file of a client was in the same place and was easily accessible.

The new VA model requires electronic filing though it is recommended that paper be kept as a backup for the clients. To evaluate this implementation, the regional managers should speak directly with the key contacts during typical meetings that currently take place. At these meetings, the manager should discuss the importance of electronic files as well as what is important to document, and the appropriate documentation manner. Additionally, any difficulties with the electronic files should be brought up and quickly directed to the appropriate personnel. The CMS should be flexible, easy to update, and user-friendly. Modifications to the structure of the CMS may be needed to ensure that the necessary information is recorded.

Additionally, training programs should be available to the staff of VA for the electronic filing system. Covered in the training program should be appropriate use of the "notes" space, the goals and outcomes section, and the complete way to close a file to include all pre- and post- assessments. At the completion of training, the staff should be able to use the CMS program effectively. To maintain this level of efficiency, files should be randomly reviewed between the key contacts and the local management to ensure all areas are being properly executed.

Measurable indications of uniform record keeping include:

- All client files are recorded electronically in the CMS.
- The CMS is structured to record all necessary information.
- All staff are trained in the use of the CMS.
- Staff at local service centers are able to access all necessary client files electronically.

4.3.3 Communication between client and organization

In the new client service model communication between client and service providers is very important. The main goal is to establish a key contact or personal liaison for every client to the organization. This individual could hold the service coordinator capacity as it

existed in the ex-RVIB model or could be a specialist who also acted in the provisionary role for a number of clients.

As the size of the organization continues to grow yearly and spans a large geographic range, it is becoming more important to clients that they recognize the individual they are working with. The clients have expressed concern about never recognizing the individuals they speak to or work with.

A key contact is responsible for the initial pre-assessment of the client. It is during these pre-assessments that initial goals are determined and documented in the client file. As this is the protocol, the easiest way to determine if every client has a key contact is to review the file. If files are periodically reviewed and the pre-assessments are present, it indicates the successful implementation of a key contact. Additionally, the team meetings already being held on a monthly basis could include reports that would later be submitted to senior managers recognizing numbers of clients per worker and goals that have been accomplished.

Similarly, the organization wants to expand upon the goal setting processes and evaluations that take place between clients and specialists. VA would like clients and service personnel to make clear goals in every area of service provision. The key contact could help in this capacity because they are supposed to form stronger bonds with the client and have a broader view of the clients' needs than individual service providers or specialists. Assessment at this level would be easiest if incorporated into the outcomes assessments that will be discussed later. However, goal setting workshops available to all specialists that would fully explain ways to communicate effectively with clients, how to appropriately document goal concepts, and ways to make quality of life goals approachable through more manageable tasks would prove valuable to all key contacts in the implementation of the more expansive goal setting process.

The key contact is the principal avenue of communication between the client and the organization. Indicators of successful communication with the client are:
- All clients are provided with a key contact.
- Broad client goals are communicated to the key contact during pre-assessment.
- Service providers document client goals for their specialties in the CMS.
- All specialists and key contacts participate in goal-setting workshops.
- Clients are contacted after conclusion of services to evaluate service delivery and outcomes. Responses are recorded in the CMS.

Evaluating the implementation of the new service model will be easiest for the organization if it focuses on the three main concepts. The first idea is that of unified client intake procedures. Once the NCC has been successfully established, it would be pertinent for information to be distributed to all organization staff concerning the role of the NCC and what is expected of the local service staff once client files have been received. Routine assessment of transferred files for accuracy, and verification from the service centers that calls can be directed to the NCC would also be beneficial.

Record keeping especially pertaining to client files was a second major theme. Training should be made available to all staff concerning the CMS electronic system as two pre-merger organizations only used paper-filing systems. Included in the training should be appropriate procedures for goal setting and outcomes evaluations as well as appropriate means to close a case. After this training, the files should be reviewed periodically by the local management to maintain accuracy.

Communication between the organization and the client through a key contact was also a major concern of the new model. Key contacts are established at intake and from there handle the initial pre-assessments. The organization should hold workshops for the key contacts to learn goal setting as well as ways to clarify with a client broad quality of life goals and then smaller task-based goals. The workshops should also address the pre-assessment methods to be employed. After these workshops, it would be beneficial for local management and key contacts to discuss at the monthly meetings already held any concerns with the overall process and the client files.

5 Outcomes Assessment

Vision Australia has a very diverse client base in age group, vision level, and goals. In order to collect relevant information regarding client outcomes, these differences must be accounted for. In general, organizations set broad goals for their clients. These goals often address qualitative outcomes. To accomplish these major goals, smaller goals that are often more concrete and task oriented are created. In terms of Vision Australia, a broad goal the organization has for its clients is independence. To achieve some level of independence requires more structured goals such as ability to travel outside the home or the ability to cook for oneself. For both of these levels, the goals that deal with quality of life as well as specific tasks, assessment tools must be used to measure the achievement of the clients' goals.

In order to better understand what is required to make meaningful assessments at each level, the project team reviewed a variety of assessment tools and instruments used by service provision organizations. These tools were evaluated in a number of ways. The first and most obvious is a tool that is used to evaluate outcomes from broad goals to more narrow and structured ones. There are two types of assessments found to be effective that differ on this level. These two types of surveys are quality of life based surveys which are ideal for situations like counseling and task oriented surveys that are ideal for specialist services. These two types of surveys have been implemented both as separate entities as well as together depending on the desired results and the specific implementation.

The surveys were also evaluated on the basis of timing. Some of the surveys are most effective if administered before service provision while others are best if given after service provision. The terms to be used for these surveys are pre-qualifying surveys and post-qualifying surveys. Depending on the objectives for employing the surveys, they can be administered as a collective series or as individual evaluations.

Finally, the surveys were analyzed based on administration and scoring. Some of the surveys have a numeric rubric while others feature open ended questions requiring discussion between client and service coordinator or service provider. It was important to consider which methods were the easiest to implement, administer and evaluate while providing sufficient information for the desired level of outcomes assessment.

5.1 Quality of life vs. task oriented surveys

During interviews, questions were posed to the service providers as well as to the regional and senior management concerning possible methods for outcomes evaluation.

These questions centered on when such evaluations could be administered and who would conduct them. One area that proved to be of great interest was the types of questions the service provision staff wanted to ask their clients.

When discussing the topic with specialists such as the OTs and the O&Ms, regardless of pre-merger affiliation, it was evident that the interaction between service provider and client was task oriented. The goals set by the clients focused on tangible tasks such as cooking (OT) and the use of a long cane for mobility (O&M). Because of this, the specialists in these areas felt that evaluations focused solely on these tangible skills would be of the most importance to both the service provider and the client. Task oriented surveys, for example the NEI-VFQ 25 and the LVQOL, were thus seen as the most useful to specialists as these particular surveys ask questions that are straightforward and focused on specific tasks and not on generalities such as overall independence.

When the same question concerning evaluation methods was posed to individuals having a background in counseling and to some extent in orthoptics (since this discipline deals with a client's perceptions of light), it was observed that very few goals in their specialties were associated with specific tasks. Instead, the client and the specialist worked towards emotional or broad goals such as independence in the home or a rise in self-esteem. To these specialists, the evaluation tool needed would not ask questions about ability to perform specific tasks but would instead focus on larger and broader concepts. To suit this purpose, quality of life surveys were seen as a possible best fit for these specialties.

Quality of life surveys were also deemed necessary by the senior development managers for funding purposes. Vision Australia has never collected tangible quality of life data, and the government funding bodies that support organizations for the disabled now require tangible information on client outcomes so that funding can be distributed to the organizations that provide the greatest impact on the lives of clients. A quality of life survey that is conducted before and after service provision appropriately serves this purpose.

5.2 Scheduling evaluations

When attempting to create a feasible evaluation technique for an organization, the types of questions to ask a client are not the only important point to consider. A second factor is the timing of administration of any evaluation tool. Just as there are different types of surveys, quality of life vs. task oriented assessments, there are also several epochs during which the outcomes assessment can be administered.

Evaluation tools can be administered both before service provision begins and also following service provision. The timing of the administration is based on the purpose of the evaluation. Surveys administered prior to service provision are most useful as a benchmark for later reflection as well as a conversational starter between service provider and client. When discussing with local service personnel the intake steps associated with goal setting, no standardized process was found. Instead, the specialist, the client and their contact (either a specialist or a service coordinator) would set goals together in a process that was not well-documented. A problem observed with this method of informal goal documentation was that following service provision, no measurable outcomes could be assessed because the starting point of the client's situation was not adequately documented. A pre-qualifying assessment administered prior to the start of service provision was seen as beneficial by both local personnel as well as senior managers. It was suggested by several employees during the interviews that a rubric for outcomes and goal setting should be available and standardized for every specialty so that following the end of service provision measurable analysis would be possible as well as a clarified idea of what the client wanted to gain with the help of the organization.

Another interesting commonality between the interviews is that many local managers and service personnel suggested that the outcomes assessment, regardless of content, be conducted by a person familiar to the client. Of the several employees that agreed that familiarity was essential to outcomes assessment, the majority preferred that the service coordinator conduct the outcomes assessment since these personnel have generally established a rapport with the client. In contrast, some VA staff argued that clients would not comfortably criticize their service providers in fear that the services would be discontinued. Clients that participated in focus groups showed no preference in the administrator of the outcomes assessment, and service coordinators showed little concern because these personnel can also serve the capacity of key contact in the new model.

Local service personnel expressed a need for a standardized method of outcomes evaluations to take place following the end of the services. These tools are called post-assessment tools. Originally, the three pre-merger organizations had individual methods by which to assess final service outcomes. In each of the three organizations, a follow up phone call was made by a service coordinator or member of the service provision team typically a month or more after the final service. The main purpose of the phone call was to determine if the client was satisfied with what was achieved as well as to maintain contact with the client should any further services be needed. Though there were questions asked during these

phone calls concerning qualitative outcomes, there was no formal, standardized documentation used consistently by any of the three pre-merger organizations. This situation did not allow useful feedback to reach the service providers so that services and products could be improved because there was no way to collect aggregate outcomes data.

It was because of this situation that local personnel interviewed from all three pre-merger organizations wanted a tool to implement following the end of service provision. They added that the evaluation should not take place more than a month following the end of service provision as the needs of the client may have changed in that time period and alter the validity of the client responses.

When the regional managers and senior managers were presented with the same question concerning timing of any outcomes evaluation tool, the majority also said they wanted to see an evaluation take place following service provision but added that they wanted the tool specifically geared towards qualitative assessments and possibly in conjunction with a tool used prior to the start of services. The reasoning for this was that the client's quality of life and ability to perform tasks could be compared on the same scale before and after service provision. The pre- and post- classifications of the assessment methods described in Chapter 2 can be found in Figure 8.

	Quality of Life Based	Task Based	Pre-qualifying assessment	Post service assessment	Open ended answers	Numerically based grading
VisQoL	**X**		**X**	**X**-limited use	**X**	
LVQoL		**X**	**X-**limited use	**X**		**X**
NEI-VFQ 25		**X**		**X**		**X**
LV VFQ 48		**X**	**X-**limited use	**X**		**X**
IVI	**X**	**X**	**X**	**X**	**X**	**X**
VF-14		**X**	**X**	**X**		**X**

Figure 8-Comparison of survey methods

5.3 Analysis methods of evaluation tools

Differences in surveying methods are accompanied by differences in the final analysis of the results. Some methods use a numeric rubric while others have open ended questions. Tools that used rubrics differ in how the results are tabulated. These differences in scoring across different evaluation tools can be found in Figure 8.

Some surveys feature open-ended questions that give rough depictions of client situations that are clarified only through conversation between service provider and client.

When explained during the interviews, this particular measure for evaluation was found to be most useful to the service personnel prior to service provision or during the actual services. They felt that this method would not be useful in terms of tangible outcomes evidence but would be useful as a catalyst for discussion of goals with the client.

Survey methods based on a numeric scale usually used a Likert scale and then had an optional response for instances when the task did not apply to the client, if they were not interested in that task, or when the task was no longer feasible because of the loss of vision. These scaling methods were usually added up by category of interest, such as independence and life skills, or as a complete unit with responses for every task being weighted equally. These totals would then be mathematically compared to scores thought to be normalized so that a quantitative result for the qualitative outcome could be rendered. When discussed during interviews, this particular analysis was thought to be ultimately more useful but also difficult for staff that are trained in other disciplines to perform. Either method could be used in the evaluation of client outcomes however the relative value of each question must first be determined.

5.4 Discussion- Outcomes assessment

Interviews with staff, focus groups with clients from the RVIB and VAF business units, and research on outcomes assessment techniques have exposed several factors that must be considered as the organization assesses client outcomes. These include:

- Qualitatively assessing outcomes for disciplines that result in both task-based and broad outcomes
- Conducting the outcomes assessment in a manner that is feasible for the organization and convenient for vision impaired clients
- Constructing an outcomes assessment framework that is conducive to the continuous improvement of client outcomes

These issues when constructing an outcomes assessment framework have been explored, and every factor has been taken into account before recommendations were formulated.

5.4.1 Diverse client base

An outcomes assessment technique must be suggested that encompasses the full realm of Vision Australia's diverse clientele. Vision Australia's clients exhibit a great range in vision acuity, lifestyles, and goals. An outcomes assessment must, then, be able to be conducted in a uniform manner that will result in reliable, accurate results. Vision Australia

also provides services for over 40,000 clients, thus the results of outcomes assessments must be relatively simple to analyze and report to government funding bodies.

The outcomes assessment measures that have been researched in this report all account for these potential hurdles. The IVI, for example, has a relatively simple scoring system that both weights every question the same and also differentiates between attributes that are most important to the client. Other quality of life assessments, such as the NEI VFQ-25, and task based assessments, such as the VF-14 or the LV VFQ-48, are easily analyzed.

The only issue that remains is suggesting an outcomes assessment technique that will accurately assess the different needs of the clients. Clients may be evaluated in areas that are of no importance to them, and areas of the most importance could be scored with the same value as outcomes of a lesser significance. The process used in the administration of the SERVQoL may be useful in this instance. The survey is administered twice, once with the clients ranking the importance of certain outcomes and task-based accomplishments and a second time during which the client assesses their achievement of the same outcomes and accomplishments. Disciplines tend to use generally different methods to evaluate whether goals have been met, thus a flexible suggestion for outcomes assessment in which an array of different tools are suggested may be best.

5.4.2 Administration of assessments

The period during which the outcomes assessment is conducted is critical to the accuracy of the outcomes information. Pre-assessment surveys are normally conducted to discern the needs of the client, a practice that service personnel agreed was necessary. Across the pre-merger business units, post-provision outcomes assessment varied greatly and in most cases the post- assessments evaluated facets of the client's vision and quality of life that differed from the pre- assessment. Service providers could also assess outcomes periodically during the service provision to account for potential changes in the condition and goals of the client and to monitor client progress. The frequency of outcomes assessments must be determined such that the clients and VA staff are not burdened by the volume of outcomes follow ups and that Vision Australia is provided with accurate and quantitative outcomes data.

5.4.3 Scoring and analysis of outcomes data

The manner in which the outcomes assessments are scored has a significant impact on how the organization collects and compiles the resulting data. The outcomes assessment must have a simple scoring method, since the results will probably be compiled internally by

personnel that lack statistical training. Many of the scoring methods including the IVI, which has seemed to meet the aforementioned criteria as well, have a numerical scoring system.

An additional question is who the organization will select to analyze the outcomes data. Outsourcing the analysis to a third party such as CERA would not take into account the goals that were set by action teams prior to the implementation of the new model, and if the third party suggested changes for continuous improvement it would take a great deal of communication to accurately implement the suggestions. The analysis would best support the needs of the organization if it was handled internally. The manner in which the analysis teams are selected must be considered when suggesting the optimum means of outcomes assessment.

5.4.4 Communication with clients

Once outcomes data have been analyzed by the organization, the client participants in the focus groups requested that Vision Australia communicate to them the manner in which the feedback provided in outcomes assessments affects VA's services. No suggestions were made during the focus groups regarding the means of communication that were convenient for the clients. A theme of the new service model is ensuring that the clients are informed of the proceedings of the organization, thus communicating how the organization handles outcomes data would be conducive to the ideology of the new model.

5.5 Recommendations- Outcomes assessments

One of the primary goals of this project was to make recommendations to Vision Australia that can be used to quantify client outcomes. The outcomes assessment framework must be conducive to continuous improvement. This project team has uncovered several aspects of client outcomes that must be accounted for, including the types of assessment, administration of the assessments, scoring the results, and the manner in which Vision Australia communicates these results to clients. In addition, a common language for describing client outcomes is imperative. The project team's recommendations on how to address these issues can be organized into a multi-step process with a common theme of maximum client involvement, as shown in Figure 9:

Pre-assessment

Client QoL goals established

Individual client communication

QoL goals not met

Identify services and establish task based goals

Task based goals not met

Post-assessment

Organizational goals not met

Aggregate outcomes data analyzed

Continuous improvement cycle

Address the problem

Organizational goals met

Communicate with clients
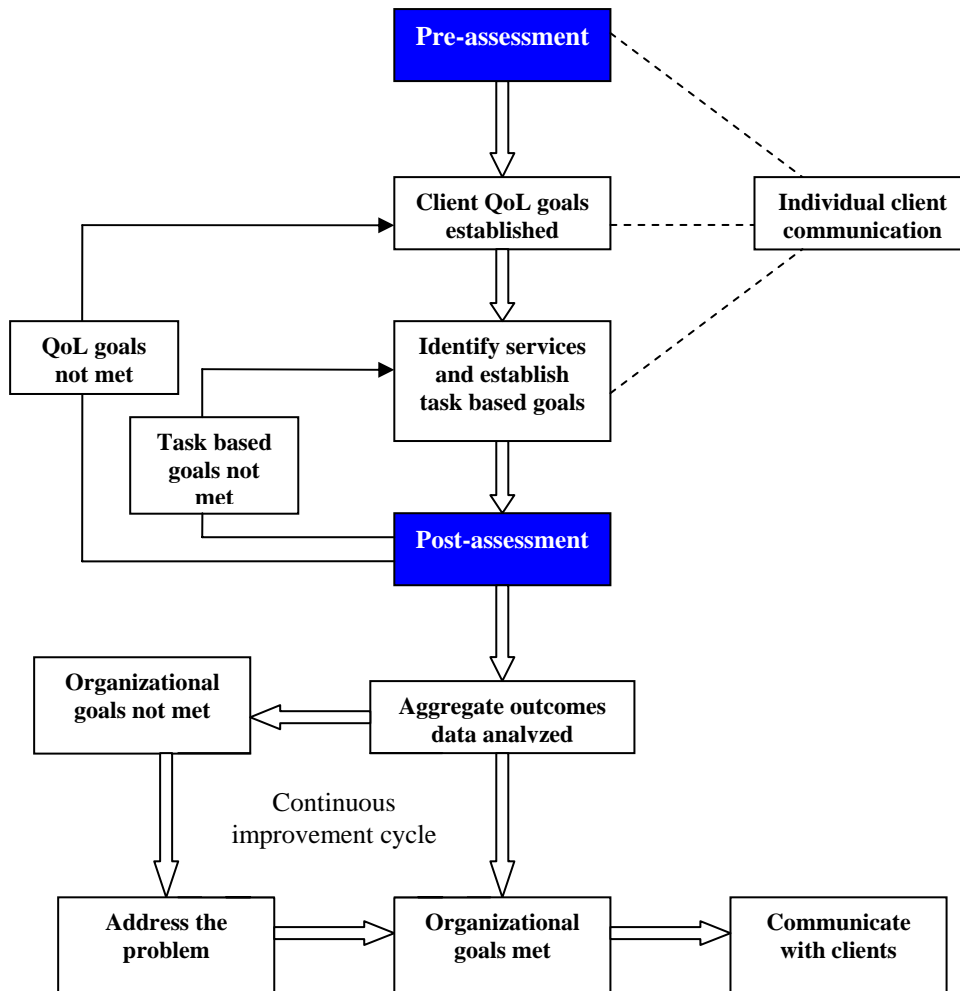
Figure 9- Outcomes assessment framework

5.5.1 Common language of client outcomes

The discussion of client outcomes has been extensive in preparation for the new service model and client outcomes assessment. As commonalities are essential for the amalgamation of the pre-merger business units, a unified yet flexible definition of client outcomes must be established. Client outcomes may include the accomplishment of specified tasks, achievement of broad life goals, or accessing the information required to increase the quality of a client's life. Outcomes are achieved through close partnership between the client and service provider to ensure that the client receives an individualized and flexible service that is directed by the client as much as possible.

Outcomes for individual disciplines have been created by the action teams in their workshops. The aforementioned definition of client outcomes encompasses the general themes that accompany successful outcomes throughout every discipline. As Vision Australia creates the directory of terminology and services, this definition ought to be kept in mind so that clients and the organization can share a common definition of outcomes. As clients enter

individual services with their own outcomes, clients would benefit from the personnel explaining the outcomes that were formulated by the action teams and how these outcomes best suit the clients.

5.5.2 Outcomes assessment technique

While researching outcomes assessment techniques and the preferred methods of implementation from Vision Australia personnel, it became apparent that both quality of life and task oriented surveying techniques were essential to quantifying client outcomes. Occupational Therapists and Orientation and Mobility instructors, in their work with specific task-based goals, require a task-based assessment such as the VF-14, the LV VFQ-48, or the LVQOL. These surveys differ based on the individual tasks and the manner in which the information is structured. It is important to note that the LV VFQ-48 has an open response scoring system that may be difficult to score and analyze.

It is also important to note that task based goals are developed in pursuit of larger, fundamental goals. These goals are also essential to the work of orthoptists, therapists, and some of the other disciplines that are not congruent throughout the pre-merger business units. Thus a quality of life tool, such as the IVI or NEI VFQ-25, would also be necessary for outcomes assessment. During the post-assessment, the quality of life and task based assessments can be reviewed and the client can reenter the service cycle based on completion of the predetermined quality of life and task based goals. The use of quality of life and task based outcomes assessments are represented in the outer and inner loops of Figure 9.

At the suggestion of senior management, a quality of life tool should be implemented across the organization in the pre-assessment. This will allow the key contact to pinpoint areas that could be strengthened by the services of Vision Australia. At the conclusion of services, a quality of life assessment would be beneficial once again. Task-based assessments would demonstrate the effectiveness of the services however a quality of life post-assessment would allow the organization to understand how accomplishing individual tasks affected the quality of the client's life.

The type of organizational goals for the service provision and the means by which the goals are to be evaluated must also be determined. A discipline-wide assessment technique should be selected by the action teams, since these teams establish the general outcomes for their field and how the outcomes will be achieved. As action teams are scheduled to disband before these suggestions are submitted, the feasibility of re-establishing action teams or forming new outcomes evaluation teams of the same structure could be explored.

5.5.3 Conducting the assessments

The administration of the assessments serves as another essential area to address. A pre-assessment is essential to understanding the needs of the client. Every service center employs a pre-assessment of some sort, thus it is imperative to prescribe something that can be conducted before the services are provided. In addition, to quantify outcomes at the conclusion of the services, a post-assessment must be conducted. This post-assessment must quantitatively analyze client outcomes on the same level as the pre-assessment so that Vision Australia can measure the impact of its services on a given client. The aforementioned surveys can all be conducted as both pre- and post- assessments. If the goals of the client have not been met, then goals are reestablished and the service provision cycle will repeat. In the event that the client has achieved acceptable individual outcomes, they exit the cycle.

One aspect of outcomes assessment that was generally agreed upon was the means of conducting the assessments. Focus group participants and local personnel (both staff and managers) agreed that a phone-based outcomes assessment would be convenient for both the staff and the client. Many local managers and staff encouraged familiarity when conducting an outcomes assessment, especially for older clients that may feel less secure with a third party. The IVI requires no training to administer, as professional survey administrators solicited the same results as assessments that were self-administered. To ensure reliable and accurate outcomes data the key contact, whether they are a multidisciplinary staff member or a specialized service coordinator, should conduct outcomes assessments with clients.

5.5.4 Means of continuous improvement

Once an assessment technique has been agreed upon, Vision Australia must aid in the progression of client outcomes through organizational improvement. This is not only one of the stipulations of the Quality Framework for Disability Services (Department of Human Services, 2007), but also serves as an effort to provide clients with an optimal service. The following suggestions for continuous improvement serve as plausible avenues through which client outcomes can be enhanced.

5.5.4.1 Use of action teams

Once the individual client outcomes assessment results have been compiled, the functions of continuous improvement can fall in the hands of the action teams. If the action teams were to determine which means of outcomes assessment to use, they could also take part in evaluating the outcomes. In the early stages of development, action teams develop goals for the individual disciplines. The teams can then periodically compare their goals to

the results of the outcomes assessments to determine areas of strength or others that necessitate improvement. The action teams could also determine the value of each question in an outcomes assessment or quantify, using outcomes scores, how aggregate outcomes data will be collected and evaluated. Another advantage to using action teams in the outcomes assessment process is that if areas were found that lacked sufficient positive outcomes, the action teams (as service personnel) not only decide on how to rectify the situation but also implement their own solution.

As action teams are only used for a period of two months, there is a possibility that these teams may not reunite for the purposes of outcomes assessment. The general layout of action teams can, however, serve as a template for an outcomes assessment team. Action teams are composed of a diverse group of individuals from similar disciplines and one person that can provide an opinion from outside that field of knowledge. The exact composition of each action team does not necessarily have to be restored when assessing outcomes, but a group of specialists that are familiar with the outcomes determined by the original action teams could effectively assess and react to outcomes data. This stage of the outcomes evaluation process requires significant planning. If Vision Australia chooses to implement an action team (or action team equivalent) in evaluating aggregate client outcomes, the timeframe and frequency of when these teams meet must first be established.

A plausible addition to the teams that discuss aggregate client outcomes would be client representatives. Clients are currently represented in local and regional groups, which contribute members to the client representative council. These representatives convey the ideas of clients to upper management. It would be possible, then, for client representatives to discuss aggregate outcomes with Vision Australia staff and collaborate in pursuit of continuous improvement. Further client participation in the continuous improvement process would adhere to the goal of the new service model in which services are client-centered.

5.5.4.2 Client activity and outcomes causation

Another aspect of continuous improvement involves the relationship between Vision Australia's services and the outcomes of its clients. While there is no guaranteed means of causation, positive client outcomes are more likely to result from VA's services if the clients are active in the decision making process. From the initial assessment to the means in which outcomes data are released to the client, increased client participation would increase causation probability and build a rapport between the client and the organization.

Increased client participation begins with an increase in client knowledge. Clients requested that Vision Australia communicate the changes that result from the outcomes data they provide. Two avenues that were suggested by local management were the Vision Australia Newsletter and Vision Australia Radio, which has a program called Around Vision Australia that could relay this information. One drawback to Vision Australia Radio is that only Victoria is broadcasting it at this time. If Vision Australia explains to the clients how outcomes data are being analyzed and the improvement process that ultimately benefits the clients, the clients would be motivated to provide thorough outcomes information.

5.5.4.3 Benchmarking

The literature revealed another means of continuous improvement that is externally dependent. This method is the comparative method of benchmarking, in which the outcomes assessment techniques and results of Vision Australia would be held up against the standards met by the industries best (Royal New Zealand Foundation for the Blind, Royal National Institute for the Blind, etc.). This would foster a relationship between leading providers of vision services that would lead to the continuous improvement of all involved. The major downfall to this strategy is that different countries have different disabilities standards. While brainstorming which international approaches are best, it is essential that none of the approaches that are considered for Vision Australia compromise the standards that were established by its governmental funding bodies.

The outcomes assessment strategies this project team suggests to Vision Australia serves as a practical means by which qualitative client outcomes can be quantitatively assessed with a cycle for continuous improvement. The outcomes assessment framework allows for the evaluation of quality of life goals, which can be used to fulfill the requirements reflected in the Quality Framework for Disability Services (Department of Human Services, 2007), as well as the task based goals of the client. The tools suggested for the evaluation of these goals have been classified as the best assessment techniques in the industry. The optimum results of this framework can only be achieved through increased involvement and communication with clients. Vision Australia seeks to place a greater emphasis on the individual client, in congruence with the new client service model. The outcomes assessment framework allows for client integration into the outcomes assessment process and is conducive to the mission statement of Vision Australia in which clients are enabled to participate in any facet of life that they choose.

6   Conclusion

In an attempt to assist Vision Australia with the amalgamation process and shift in attention to individual client outcomes, this project team developed a framework for the assessment of client outcomes and evaluation suggestions for the implementation of the new client service model. Literature research, interviews with all levels of the organization, and focus groups with current clients were used to formulate the deliverables for this project.

For evaluating the implementation of the new client service model, it was suggested that Vision Australia look to resolve the discrepancies between the pre-merger organizations across three main areas: client intake procedures, record keeping and data collection, and communication between clients and the organization. Successful implementation of the new service model in these areas will allow for fluid implementation of the other components of the model across the pre-merger business units. Several measurable indicators of progress in implementing the service model have been identified for each of the three areas. The implementation of a new client service model across thirty-three service centers serves as a daunting task, however these key indicators can be used to monitor progress towards the unification of the organization.

To assess client outcomes, a framework was developed that included the type of assessment, the means of conducting the assessment, and the manner in which Vision Australia involves its clients. The suggested assessment tools allow for the evaluation of both quality of life and task based goals and have been established as the premiere client outcomes assessment techniques in the industry. This outcomes assessment framework allows for a cycle of continuous organizational improvement through which client outcomes are evaluated and internally analyzed. Maximum client participation during this process is essential to causation of positive client outcomes and the focus of the new service model on the individual client.

These suggestions will help Vision Australia move forward as a unified organization with a focus on client outcomes. The government disability regulations will be effectively met, and the organization can improve client outcomes through internal analysis by service personnel who can then implement the solutions that they devise. In the amalgamation of three organizations into a unified effort, these suggestions are an essential component to enhancing the quality of the lives of vision impaired Australians.

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8 Appendix A

Questionnaire found on the AAD website
<http://www.aad.org.au/download/SupplyDemand_AuslanInterpreters.pdf.>
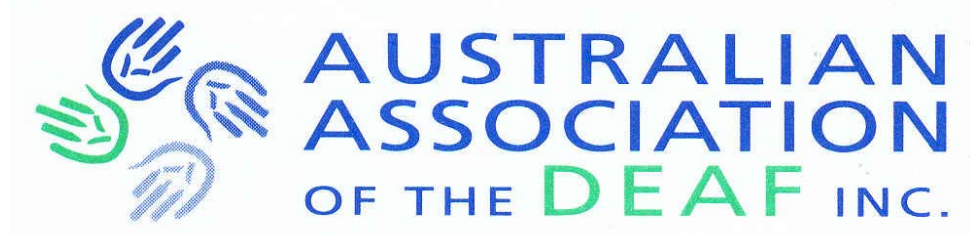
Supply and Demand for Auslan Interpreting:
the Deaf Perspective

Questionnaire

To be used with discussion paper – please read the discussion paper or attend a community consultation before you fill in this questionnaire.

Some brief information about you

We do not need to know your name or address. But we do need to know the following information. Please tell us:

Are you: ☐ Male   ☐ Female

How old are you?   ☐ 0 – 15   ☐ 16 – 25

☐ 26 – 35   ☐ 36 – 45

☐ 46 – 55   ☐ 56 – 65

☐ 65+

Which state / territory do you live in?   ☐ ACT   ☐ NSW

☐ NT   ☐ QLD

☐ SA   ☐ TAS

☐ VIC   ☐ WA

What is your postcode? _____

What kind of work do you do (e.g. Office work, Teacher, Carpenter etc):

_____

_____

_____

___

Are you: ☐ Deaf   or   ☐ Hard of hearing

_____

Demand for Auslan Interpreters

1. Which situations do you use interpreters for (tick as many as apply):

☐ doctors appointments   ☐ public hospitals

☐ other health professionals   ☐ education

☐ workplace meetings   ☐ conferences

☐ courts   ☐ employment services

☐ meetings with government departments and agencies (eg Centrelink)

☐ Other (please state what type of situation)

_____

On average how often do you need an interpreter?

☐ More than once a week   ☐ Once a week

☐ Once a fortnight (2 weeks)   ☐ Once e a month

☐ Once every 2-3 months   ☐ Other (please state what):

_____

In the past 12 months, has it been difficult for you to get an interpreter for any of these situations (tick as many as apply):

☐ doctors appointments   ☐ public hospitals

☐ other health professionals   ☐ education

☐ workplace meetings   ☐ conferences

☐ courts   ☐ employment services

☐ meetings with government departments and agencies (eg Centrelink)

☐ Other (please state what type of situation)

_____

On average, how often is it difficult for you to get an interpreter?

☐ More than once a week   ☐ Once a week

☐ Once a fortnight (2 weeks)   ☐ Once e a month

☐ Once every 2-3 months   ☐ Other (please state what):

_____

In the past 12 months, have not got an interpreter for any of the above situations even though you needed one?

☐ Yes   ☐ No

If you said yes, why could you not get one:

☐ I asked but was told no   ☐ I did not feel confident enough to ask

☐ I did not know I could ask for an interpreter

☐ Other reason (please say what):

_____

In the past 12 months, have you had to wait a long time to do something because an interpreter had to be booked? How long did you have to wait?

☐ One week   ☐ Two weeks   ☐ Three weeks

☐ Four weeks   ☐ More than four weeks

In the table below please tick as many as apply to you:

In the past 12 months:

	I got interpreter free	I paid for interpreter	I did this without an interpreter
Family / social, e.g. weddings	☐	☐	☐
Children's activities, e.g. school visit	☐	☐	☐
Purchasing goods and services	☐	☐	☐
Sporting activities	☐	☐	☐
Community meetings	☐	☐	☐
Public speeches	☐	☐	☐
Live theatre performances	☐	☐	☐
Emergencies, e.g. roadside help	☐	☐	☐
Religious, e.g. church services	☐	☐	☐
Non-job related education or hobby courses	☐	☐	☐
Private hospitals	☐	☐	☐
Private legal, e.g. solicitor	☐	☐	☐
Counselling, e.g. marriage, personal	☐	☐	☐
Financial advice and counseling	☐	☐	☐
Employment situations e.g. professional development	☐	☐	☐
Other (please state what)	☐	☐	☐

8. In the table below please tick as many as apply to you:

	I would do it if interpreter is free	I would pay for interpreter if can't get free interpreter
Family / social, e.g. weddings	☐	☐
Children's activities, e.g. school visit	☐	☐
Purchasing goods and services	☐	☐
Sporting activities	☐	☐
Community meetings	☐	☐
Public speeches	☐	☐
Live theatre performances	☐	☐
	I would do it if interpreter is free	I would pay for interpreter if can't get free interpreter
Emergencies, e.g. roadside help	☐	☐
Religious, e.g. church services	☐	☐
Non-job related education or hobby courses	☐	☐
Private hospitals	☐	☐
Private legal, e.g. solicitor	☐	☐
Counselling, e.g. marriage, personal	☐	☐
Financial advice and counseling	☐	☐
Employment situations e.g. professional development	☐	☐
Other (please state what)	☐	☐

Supply of Auslan Interpreters

Do you think there are enough interpreters in your area?

☐ Yes   ☐ No

In the past 12 months, have you requested an interpreter and been told by an agency that they could not find one?

☐ Yes   ☐ No

If you said yes, how many times did this happen in the past 12 months?
_____

When you use interpreters, do you mostly need:

☐ Para-professional (level 2) interpreters; or

☐ Professional Interpreter (level 3) interpreters; or

☐ Sometimes level 2, sometimes level 3.

If you need level 3 interpreters can you usually get them when you need them?

☐ Yes (often or always)　　　☐ No (not often or never)　　　☐ Sometimes

If you need level 3 interpreters and the agency can't supply one, do you accept a level 2 interpreter?

☐ Yes　　　☐ No　　　☐ Sometimes

If the agency can't supply the interpreter you need, or another interpreter suitably qualified and acceptable to you, would you accept any available interpreter regardless of their qualification, skill, ethics etc?

☐ Yes　　　☐ No

Do you think agencies should send non-accredited (not qualified) interpreters to your appointments if they can't find an accredited (qualified) interpreter?

☐ Yes　　　☐ No

Do you know who to ask when you need an interpreter?

☐ Yes (often or always)　　　☐ No (not often or never)　　　☐ Sometimes

Which would you prefer to have (tick one only):

☐ One agency supplying interpreters for all situations everywhere in Australia

☐ One agency in each state/territory supplying interpreters for all situations in each state/territory – eg
　　　one agency in NSW for all interpreting bookings in NSW;
　　　one agency in QLD for all interpreting bookings in QLD;
　　　etc

☐ A lot of different agencies competing with each other and supplying interpreters for all types of situations

☐ A few national agencies supplying interpreters for specific types of appointments – eg
　　　one agency for all health interpreting everywhere in Australia;
　　　one agency for all educational interpreting everywhere in Australia;
　　　one agency for all legal interpreting everywhere in Australia;
　　　one agency for all employment and community interpreting in Australia.

☐ A few agencies in each state supplying interpreters for specific types of appointments in their state – eg
　　　one agency for all health interpreting in NSW;
　　　one agency for all educational interpreting in NSW;
　　　one agency for all legal interpreting in NSW;
　　　one agency for all employment and community interpreting in NSW;

　　　one agency for all health interpreting in QLD;
　　　one agency for all educational interpreting in QLD;

one agency for all legal interpreting in QLD;
one agency for all employment and community interpreting in QLD;

etc

☐ Other (please explain what):

_____

_____

—

Who supplies the interpreters you use (tick as many as apply to you):

☐ I don't know

☐ NABS

☐ Deaf Society

☐ Private agency

☐ General interpreting agency (for all languages)

☐ Organisation's own list of interpreters (eg TAFE, university, Centrelink)

☐ Freelance – I contact the interpreters directly myself

☐ Other (please state what):

_____

Do you contact agencies and book your own interpreters yourself?

☐ Yes (often or always)   ☐ No (not often or never)   ☐ Sometimes

If you said no, please tell us why not:

☐ The agency(s) does not allow Deaf people to make bookings themselves

☐ I did not know I could book my own interpreters myself

☐ I do not know how to contact the agency(s)

☐ It is not easy for me to contact the agency(s) (eg I don't have a fax machine)

☐ I am not confident enough to book my own interpreters, but I would like to

☐ I am happy for the agency(s) to decide which interpreter I should have

Do you get the interpreters you ask for?

☐ Yes (often or always)   ☐ No (not often or never)   ☐ Sometimes

If your preferred interpreter/s is not available, does the agency contact you to discuss a suitable alternative interpreter?

☐ Yes (often or always)   ☐ No (not often or never)   ☐ Sometimes

Does the agency give you a list of interpreters' names that you can choose from?

☐ Yes (often or always)   ☐ No (not often or never)   ☐ Sometimes

In the last 12 months have any interpreters pressured you to choose them for your appointments?

☐ Yes   ☐ No

To get an interpreter, how far ahead do you usually need to request interpreters from most agencies?

☐ One day or less   ☐ A few days   ☐ One week

☐ Two weeks   ☐ Three weeks   ☐ More than three weeks

Do agencies ask you to change your appointment times?

☐ Yes (often or always)   ☐ No (not often or never)   ☐ Sometimes

When you book your own interpreter do most agencies contact you and confirm your interpreter has been booked?

☐ Yes (often or always)   ☐ No (not often or never)   ☐ Sometimes

On the day of your appointment does the interpreter you booked usually turn up, or does the agency send you someone else?

☐ The interpreter I booked usually turns up

☐ The agency often sends a different interpreter

☐ The agency sometimes sends a different interpreter

If the agency sends a different interpreter do they check first with you that the new interpreter is acceptable to you?

☐ Yes (often or always)   ☐ No (not often or never)   ☐ Sometimes

What do you do when you need an interpreter but can't get one at short notice (tick as many as apply)?

☐ I cancel the appointment / do not attend the event

☐ I accept a non-accredited interpreter

☐ I ask someone who can sign a bit to help me

☐ I ask someone to take notes for me

☐ I use pen and paper and ask the other person to use pen and paper

☐ I organise real time captioning services instead

☐ I muddle through as best I can with gestures, lipreading, speech etc

☐ I ask NABS to find me an interpreter even if it is not a health appointment

☐ Other (please state what):

_____

Do you know how agencies make decisions about which interpreters to assign to your appointments?

☐ Yes   ☐ No   ☐ Some agencies

If you said yes or some agencies, how do you know?

☐ The agency has asked me to tell them which interpreters I prefer and they always or almost always send me these interpreters

☐ I have told the agency which interpreters I prefer, and which interpreters to not send me, and they almost always send me my preferred interpreters

☐ Someone who works at the agency told me how they make these decisions

☐ Other (please state what):

_____

Sometimes agencies only send one interpreter for a long meeting and the interpreter has to have breaks in the middle of the meeting. This means the meeting has to either stop while the interpreter has a break or the Deaf person has to miss out on access until the interpreter comes back. Has this happened to you?

☐ Yes   ☐ No

When meetings run over time or lunch and tea breaks are shorter than planned, some interpreters are flexible and do not mind; others are not flexible. In this situation what usually happens for you?

☐ Most of my interpreters are flexible and do not mind

☐ Most of my interpreters complain

☐ Some interpreters are flexible and some complain

Who should be responsible for letting meeting leaders know when the interpreter needs a break?

☐ The Deaf person

☐ The interpreter

☐ The interpreting agency

☐ The meeting leader should remember

Most agencies charge a minimum 2 hour booking fee even if we only need an interpreter for a very short time. Do you think it would be fair if agencies changed this and only charge for the actual time we need the interpreter plus a travel charge?

☐ Yes   ☐ No

Do you think that any interpreter (even if their skills or their ethics are not very good) is better than not having an interpreter at all?

☐ Yes   ☐ No

Do your interpreters have the appropriate specialist knowledge or skills needed for the job (e.g. do they know what medical words or legal words mean and how to sign them)?

☐ Yes (often or always)   ☐ No (not often or never)   ☐ Sometimes

Do you think interpreters should be required to do regular professional development activities to upgrade their skills?

        ☐ Yes   ☐ No

Do you think that if agencies have a cancellation policy they should be required to supply a suitable interpreter (i.e. if your interpreter is sick they must send another suitable interpreter)?

        ☐ Yes   ☐ No

If you said yes:
If the agency cannot supply a suitable interpreter, do you think they should compensate you?

        ☐ Yes   ☐ No

Some interpreters cancel a job to do another job with a different agency because the other job pays more. We do not always know that this is why they have cancelled but sometimes we do. Do you know of any occasions when an interpreter has cancelled a booking with you because they got a better paying assignment at the same time as your appointment?

        ☐ Yes   ☐ No

Do agencies invite you to meetings / events so they can give you information about their interpreting services?

        ☐ Yes   ☐ No

Do agencies invite you to meetings / events so you can tell them what you think about their interpreting services?

        ☐ Yes   ☐ No

Do you think that agencies should be required to meet certain standards and practices (rules)?

        ☐ Yes   ☐ No

If you said yes, who should develop these standards and practices (rules)?

_____
__

Who should watch and make sure the agencies follow the standards and practices (rules)?

_____
___

Do you think the fees that agencies charge ($110 - $270 for 2 hours minimum fee) are:

        ☐ About right   ☐ Too low   ☐ Too high

Do you think it would be better if agencies stopped providing free interpreting for some things (e.g. funerals) so that they can charge lower fees for other things? ?

        ☐ Yes   ☐ No

Do you think that agencies should charge different rates for level 2 interpreters and level 3 interpreters?

☐ Yes   ☐ No

46. If you are not happy with an interpreter do you know how to make a complaint?

☐ Yes   ☐ No

In the past 12 months have you made a complaint?

☐ Yes   ☐ No

If you said no, why not?

☐ I have not needed to make a complaint

☐ I do not know how to make a complaint

☐ The complaint process is hard for me to use – e.g. it requires me to write my complaint and I am not good at writing English

☐ I am frightened to make a complaint

☐ Other (please state what): _____

If you said yes was your complaint followed up (the agency responded to your complaint) and resolved?

☐ It was followed up and I was happy with the response I got

☐ It was followed up but I was not happy with the response I got

☐ It was not followed up

☐ I have made a complaint within the past month and am waiting for follow up

Some agencies give you a form or card to fill out and return to them, this is a general feedback form/card to tell them if you have been happy or unhappy with their service. In the past 12 months have you been given any feedback forms or cards?

☐ Yes   ☐ No

If you said yes, did you fill it out and give / send it back to the agency?

☐ Yes   ☐ No

If you said yes, was your feedback:

☐ Positive (you were generally happy with the service)

☐ Negative (you were generally not happy with the service)

Is there anything else you would like to tell us about your experiences and views about interpreting services?

9 Appendix B

Final VisQoL items (Misajon, 2005)

Q1 Does my vision make it likely I will injure myself (i.e. when moving around the house, yard, neighborhood, or workplace)?
☐ It is most unlikely I will injure myself because of my vision.
☐ There is a small chance.
☐ There is a good chance.
☐ It is very likely.
☐ Almost certainly my vision will cause me to injure myself.

Q2 Does my vision make it difficult to cope with the demands in my life?

My vision
☐ has no affect on my ability to cope with the demands in my life.
☐ does not make it difficult at all to cope with the demands in my life.
☐ makes it a little difficult to cope.
☐ makes it moderately difficult to cope.
☐ makes it very difficult to cope.
☐ makes me unable to cope at all.

Q3 Does my vision affect my ability to have friendships?

My vision
☐ makes having friendships easier.
☐ has no effect on my friendships.
☐ makes friendships more difficult.
☐ makes friendships a lot more difficult.
☐ makes friendships extremely difficult.
☐ makes me unable to have friendships.
☐ Not applicable; I have no friendships.

Q4 Do I have difficulty organizing any assistance I may need?
☐ I have no difficulty organizing any assistance I may need.
☐ I have a little difficulty organizing assistance.
☐ I have moderate difficulty organizing assistance.
☐ I have a lot of difficulty organizing assistance.
☐ I am unable to organize assistance at all.
☐ Not applicable; I never need to organize assistance.

Q5 Does my vision make it difficult to fulfil the roles I would like to fulfil in life (e.g., family roles, work roles, community roles)?

My vision
☐ has no effect on my ability to fulfill these roles.
☐ does not make it difficult to fulfill these roles.
☐ makes it a little difficult to fulfill these roles.
☐ makes it moderately difficult to fulfill these roles.
☐ makes it very difficult to fulfill these roles.
☐ means I am unable to fulfill these roles.

Q6 Does my vision affect my confidence to join in everyday activities?

My vision
☐ makes me more confident to join in everyday activities.
☐ has no effect on my confidence to join in everyday activities.
☐ makes me feel a little less confident.
☐ makes me feel moderately less confident.
☐ makes me feel a lot less confident.
☐ makes me not confident at all.

10 Appendix C

LVQOL survey from *Wolffsohn et al.*

Distance Vision, Mobility and Lighting

How much of a problem do you have:	None		Moderate		Great		
With your vision in general	5	4	3	2	1	x	n/a
With your eyes getting tired (e.g only being able to do a task for a short period of time)	5	4	3	2	1	x	n/a
With your vision at night inside the house	5	4	3	2	1	x	n/a
Getting the right amount of light to be able to see	5	4	3	2	1	x	n/a
With glare (e.g dazzled by car lights or the sun)	5	4	3	2	1	x	n/a
Seeing street signs	5	4	3	2	1	x	n/a
Seeing the television (appreciating the pictures)	5	4	3	2	1	x	n/a
Seeing moving objects (e.g. cars on the road)	5	4	3	2	1	x	n/a
With judging the depth or distance of items (e.g. reaching for a glass)	5	4	3	2	1	x	n/a
Seeing steps or curbs	5	4	3	2	1	x	n/a
Getting around outdoors (e.g. on uneven pavements) because of your vision	5	4	3	2	1	x	n/a
Crossing a road with traffic because of your vision	5	4	3	2	1	x	n/a

(GRADING header above None / Moderate / Great)

Adjustment

Because of your vision, are you:	No		Moderately		Greatly		
Unhappy at your situation in life	5	4	3	2	1	x	n/a
Frustrated at not being able to do certain tasks	5	4	3	2	1	x	n/a
Restricted in visiting friends or family	5	4	3	2	1	x	n/a

	Well				Poorly	Not explained
How well has your eye condition been explained to you	5	4	3	2	1	x

Reading and Fine Work

With your reading aids / glasses, if used, how much of a problem do you have:	None		Moderate		Great		
Reading large print (e.g. newspaper headlines)	5	4	3	2	1	x	n/a
Reading newspaper text and books	5	4	3	2	1	x	n/a
Reading labels (e.g. on medicine bottles)	5	4	3	2	1	x	n/a
Reading your letters and mail	5	4	3	2	1	x	n/a
Having problems using tools (e.g. threading a needle or cutting)	5	4	3	2	1	x	n/a

Activities of Daily Living

With your reading aids / glasses, if used, how much of a problem do you have:	None		Moderate		Great		
Finding out the time for yourself	5	4	3	2	1	x	n/a
Writing (e.g. cheques or cards)	5	4	3	2	1	x	n/a
Reading your own hand writing	5	4	3	2	1	x	n/a
With your every day activities (e.g. house-hold chores)	5	4	3	2	1	x	n/a

FIGURE 1. The LVQOL. Patients are asked to complete the questions by circling the number most appropriate to how they feel. If they can no longer perform the task because of their vision, they are to circle "x," and if they do not perform the task for nonvisual reasons, to circle "n/a".

11 Appendix D

NEI-VFQ 25 questionnaire retrieved from
www.nei.nih.gov/resources/visionfunction/vfq_ia.pdf

National Eye Institute
Visual Functioning Questionnaire - 25
(VFQ-25)

version 2000

(INTERVIEWER ADMINISTERED FORMAT)

January 2000

Instructions:

I'm going to read you some statements about problems which involve your vision or feelings that you have about your vision condition. After each question I will read you a list of possible answers. Please choose the response that best describes your situation.

Please answer all the questions as if you were wearing your glasses or contact lenses (if any).

Please take as much time as you need to answer each question. All your answers are confidential. In order for this survey to improve our knowledge about vision problems and how they affect your quality of life, your answers must be as accurate as possible. Remember, if you wear glasses or contact lenses for a particular activity, please answer all of the following questions as though you were wearing them.

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Visual Functioning Questionnaire - 25

PART 1 - GENERAL HEALTH AND VISION

1.   In general, would you say your overall health is*:

(Circle One)

READ CATEGORIES:		
	Excellent	1
	Very Good	2
	Good...................................	3
	Fair.....................................	4
	Poor....................................	5

2.   At the present time, would you say your eyesight using both eyes (with glasses or contact lenses, if you wear them) is excellent, good, fair, poor, or very poor or are you completely blind?

(Circle One)

READ CATEGORIES:		
	Excellent	1
	Good...................................	2
	Fair.....................................	3
	Poor....................................	4
	Very Poor	5
	Completely Blind..............	6

---

* Skip Question 1 when the VFQ-25 is administered at the same time as the SF-36 or RAND 36-Item Health Survey 1.0

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3. How much of the time do you <u>worry</u> about your eyesight?

(Circle One)

READ CATEGORIES:

None of the time............................	1
A little of the time.........................	2
Some of the time	3
Most of the time	4
All of the time?.............................	5

4. How much <u>pain or discomfort</u> have you had <u>in and around your eyes</u> (for example, burning, itching, or aching)? Would you say it is:

(Circle One)

READ CATEGORIES:

None	1
Mild.....................................	2
Moderate	3
Severe, or...........................	4
Very severe?......................	5

PART 2 - DIFFICULTY WITH ACTIVITIES

The next questions are about how much difficulty, if any, you have doing certain activities wearing your glasses or contact lenses if you use them for that activity.

5. How much difficulty do you have <u>reading ordinary print in newspapers</u>? Would you say you have:
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all..	1
A little difficulty..	2
Moderate difficulty..	3
Extreme difficulty..	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

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6. How much difficulty do you have doing work or hobbies that require you to <u>see well up close</u>, such as cooking, sewing, fixing things around the house, or using hand tools? Would you say:
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

7. Because of your eyesight, how much difficulty do you have <u>finding something on a crowded shelf</u>?
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

8. How much difficulty do you have <u>reading street signs or the names of stores</u>?
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all	1
A little difficulty	2
Moderate difficulty	3
Extreme difficulty	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

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9. Because of your eyesight, how much difficulty do you have <u>going down steps, stairs, or curbs in dim light or at night</u>?
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all... 1

A little difficulty... 2

Moderate difficulty.. 3

Extreme difficulty.. 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not
interested in doing this 6

10. Because of your eyesight, how much difficulty do you have <u>noticing objects off to the side while you are walking along</u>?
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all... 1

A little difficulty... 2

Moderate difficulty.. 3

Extreme difficulty.. 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not
interested in doing this 6

11. Because of your eyesight, how much difficulty do you have <u>seeing how people react to things</u> you say?
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all... 1

A little difficulty... 2

Moderate difficulty.. 3

Extreme difficulty.. 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not
interested in doing this 6

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12. Because of your eyesight, how much difficulty do you have <u>picking out and matching your own clothes</u>?
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not
    interested in doing this 6

13. Because of your eyesight, how much difficulty do you have <u>visiting with people in their homes, at parties, or in restaurants</u> ?
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not
    interested in doing this 6

14. Because of your eyesight, how much difficulty do you have <u>going out to see movies, plays, or sports events</u>?
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not
    interested in doing this 6

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15. Now, I'd like to ask about <u>driving a car</u>. Are you <u>currently driving</u>, at least once in a while?

(Circle One)

Yes .... **1** *Skip To Q 15c*

No **2**

15a. IF NO, ASK: Have you <u>never</u> driven a car or have you <u>given up driving</u>?

(Circle One)

Never drove ...... **1** *Skip To Part 3, Q 17*

Gave up **2**

15b. IF GAVE UP DRIVING: Was that <u>mainly because of your eyesight</u>, <u>mainly for some other reason</u>, or because of <u>both your eyesight and other reasons</u>?

(Circle One)

Mainly eyesight .... **1** *Skip To Part 3, Q 17*

Mainly other reasons .... **2** *Skip To Part 3, Q 17*

Both eyesight and other reasons ... **3** *Skip To Part 3, Q 17*

15c. IF CURRENTLY DRIVING: How much difficulty do you have <u>driving during the daytime in familiar places</u>? Would you say you have:

(Circle One)

No difficulty at all **1**
A little difficulty **2**
Moderate difficulty **3**
Extreme difficulty **4**

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16. How much difficulty do you have <u>driving at night</u>? Would you say you have: (READ CATEGORIES AS NEEDED)

<div align="right"><i>(Circle One)</i></div>

No difficulty at all................................... 1

A little difficulty...................................... 2

Moderate difficulty................................ 3

Extreme difficulty.................................. 4

Have you stopped doing this because
   of your eyesight................................. 5

Have you stopped doing this for other
   reasons or are you not interested in
   doing this 6

16a. How much difficulty do you have <u>driving in difficult conditions, such as in bad weather, during rush hour, on the freeway, or in city traffic</u>? Would you say you have:
(READ CATEGORIES AS NEEDED)

<div align="right"><i>(Circle One)</i></div>

No difficulty at all................................... 1

A little difficulty...................................... 2

Moderate difficulty................................ 3

Extreme difficulty.................................. 4

Have you stopped doing this because
   of your eyesight................................. 5

Have you stopped doing this for other
   reasons or are you not interested in
   doing this 6

<div align="center">© R 1996</div>

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PART 3: RESPONSES TO VISION PROBLEMS

The next questions are about how things you do may be affected by your vision. For each one, I'd like you to tell me if this is true for you <u>all</u>, <u>most</u>, <u>some</u>, <u>a little</u>, or <u>none</u> of the time.

(Circle One On Each Line)

READ CATEGORIES:	All of the time	Most of the time	Some of the time	A little of the time	None of the time
17. <u>Do you accomplish less</u> than you would like because of your vision?	1	2	3	4	5
18. <u>Are you limited</u> in how long you can work or do other activities because of your vision?	1	2	3	4	5
19. How much does pain or discomfort <u>in or around your eyes</u>, for example, burning, itching, or aching, keep you from doing what you'd like to be doing? Would you say:	1	2	3	4	5

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For each of the following statements, please tell me if it is <u>definitely true</u>, <u>mostly true</u>, <u>mostly false</u>, or <u>definitely false</u> for you or you are <u>not sure</u>.

(Circle One On Each Line)

		Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
20.	I <u>stay home most of the time</u> because of my eyesight.....	1	2	3	4	5
21.	I feel <u>frustrated</u> a lot of the time because of my eyesight...............................	1	2	3	4	5
22.	I have <u>much less control</u> over what I do, because of my eyesight.	1	2	3	4	5
23.	Because of my eyesight, I have to <u>rely too much on what other people tell me</u>..	1	2	3	4	5
24.	I <u>need a lot of help</u> from others because of my eyesight...............................	1	2	3	4	5
25.	I worry about <u>doing things that will embarrass myself or others</u>, because of my eyesight...............................	1	2	3	4	5

That's the end of the interview. Thank you very much for your time and your help.

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Appendix of Optional Additional Questions

SUBSCALE: GENERAL HEALTH

A1. How would you rate your <u>overall health</u>, on a scale where zero is <u>as bad as death</u> and 10 is <u>best</u> possible health?

(Circle One)

0	1	2	3	4	5	6	7	8	9	10

Worst   Best

SUBSCALE: GENERAL VISION

A2. How would you rate your eyesight now (with glasses or contact lens on, if you wear them), on a scale of from 0 to 10, where zero means the worst possible eyesight, as bad or worse than being blind, and 10 means the best possible eyesight?

(Circle One)

0	1	2	3	4	5	6	7	8	9	10

Worst   Best

SUBSCALE: NEAR VISION

A3. Wearing glasses, how much difficulty do you have <u>reading the small print in a telephone book, on a medicine bottle, or on legal forms</u>? Would you say:
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all 1
A little difficulty 2
Moderate difficulty 3
Extreme difficulty 4
Stopped doing this because of your eyesight 5
Stopped doing this for other reasons or not
      interested in doing this 6

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A4. Because of your eyesight, how much difficulty do you have <u>figuring out whether bills you receive are accurate</u>?
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not
interested in doing this 6

A5. Because of your eyesight, how much difficulty do you have doing things like <u>shaving, styling your hair, or putting on makeup</u>?
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not
interested in doing this 6

SUBSCALE: DISTANCE VISION

A6. Because of your eyesight, how much difficulty do you have <u>recognizing people you know from across a room</u>?
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all 1

A little difficulty 2

Moderate difficulty 3

Extreme difficulty 4

Stopped doing this because of your eyesight 5

Stopped doing this for other reasons or not
interested in doing this 6

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A7. Because of your eyesight, how much difficulty do you have <u>taking part in active sports or other outdoor activities that you enjoy</u> (like golf, bowling, jogging, or walking)?
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all..	1
A little difficulty...	2
Moderate difficulty...	3
Extreme difficulty...	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

A8. Because of your eyesight, how much difficulty do you have <u>seeing and enjoying programs on TV</u>?
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all..	1
A little difficulty...	2
Moderate difficulty...	3
Extreme difficulty...	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

SUBSCALE: SOCIAL FUNCTION

A9. Because of your eyesight, how much difficulty do you have <u>entertaining friends and family in your home</u>?
(READ CATEGORIES AS NEEDED)

(Circle One)

No difficulty at all..	1
A little difficulty...	2
Moderate difficulty...	3
Extreme difficulty...	4
Stopped doing this because of your eyesight	5
Stopped doing this for other reasons or not interested in doing this	6

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SUBSCALE: DRIVING

A10. [This items, "driving in difficult conditions", has been included as item 16a as part of the base set of 25 vision-targeted items.]

SUBSCALE: ROLE LIMITATIONS

A11. The next questions are about things you may do because of your vision. For each item, I'd like you to tell me if this is true for you <u>all</u>, <u>most</u>, <u>some</u>, <u>a little</u>, or <u>none</u> of the time.
(READ CATEGORIES AS NEEDED)

(Circle One On Each Line)

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
a.	<u>Do you have more help</u> from others because of your vision?	1	2	3	4	5
b.	<u>Are you limited</u> in the kinds of things you can do because of your vision?	1	2	3	4	5

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SUBSCALES: WELL-BEING/DISTRESS (#A12) and DEPENDENCY (#A13)

The next questions are about how you deal with your vision. For each statement, please tell me if it is <u>definitely true</u>, <u>mostly true</u>, <u>mostly false</u>, or <u>definitely false</u> for you or you <u>don't know</u>.

(Circle One On Each Line)

	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
A12. I am often <u>irritable</u> because of my eyesight.	1	2	3	4	5
A13. I <u>don't go out of my home alone</u>, because of my eyesight..............................	1	2	3	4	5

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12 Appendix E

LV VFQ 48 from Stelmack 2004

TABLE 1. Items Included in the 48-Item Field Test
Version VA LV VFQ

1. Physically get dressed
2. Keep clean
3. Identify medicine
4. Tell time
5. Identify money
6. Match clothes
7. Groom yourself
8. Identify food on a plate
9. Eat and drink neatly
10. Fix a snack
11. Prepare meals
12. Use appliance dials
13. Clean the house
14. Handle finances
15. Make out a check
16. Take a message
17. Find something on a crowded shelf
18. Find public restrooms
19. Get around indoors in places you know
20. Get around outdoors in places you know
21. Get around in unfamiliar places
22. Go out At night
23. Go down steps in dim light
24. Adjust to bright light
25. Cross streets at traffic lights
26. Use public transportation
27. Get around in a crowd
28. Avoid bumping into things
29. Recognize persons up close
30. Recognize persons from across the room
31. Read street signs and store names
32. Read headlines
33. Read menus
34. Read newspaper or magazine articles
35. Read mail
36. Read small print on package labels
37. Read print on TV
38. Keep your place while reading
39. Watch TV
40. Play table and card games
41. See photos
42. Work on your favorite hobby
43. Go to movies
44. Go to spectator events
45. Play sports
46. Do yard work
47. Sign your name
48. Read signs

13 Appendix F

VF-14 survey questions (Stelmack, 2001).

1. Read small print, such as labels on medicine bottles, a telephone book, or food labels.
2. Reading a newspaper or book.
3. Reading a large-print book or newspaper or the numbers on a telephone.
4. Recognizing people when they are close to you.
5. Seeing steps, stairs, or curbs.
6. Reading traffic, street, or store signs.
7. Doing fine handwork such as sewing, knitting, crocheting, or carpentry.
8. Writing checks or filling out forms.
9. Playing games such as bingo, dominos, card games, or mahjong.
10. Taking part in sports such as bowling, handball, tennis, or golf.
11. Cooking.
12. Watching television.
13. Daytime driving.
14. Nighttime driving.

Scale   0 = No difficulty performing task
           1 = A little difficulty performing task
           2= Moderate difficulty performing task
           3= Great deal of difficulty performing task
           4= Unable to perform task

14 Appendix G

Impact Of Vision Impairment Profile Questionaire

The 32-item Impact of Vision Impairment Profile (IVI) has been designed to quantify a person's handicap or their restriction to participate in their society caused by their vision impairment.

The IVI is now being administered to people who have a vision impairment and have not received low vision rehabilitation for further validation of content and structure and to evaluate the instrument's ability to measure change in handicap as a result of rehabilitation.

The IVI questions shown here are not in their complete form.

INSTRUCTIONS

Please read each question carefully and circle the answer that BEST applies to you. Put one circle on each row.

If you use GLASSES, CONTACT LENSES OR MAGNIFIERS for some activities please answer according to how you can see when using them.

Here are two *examples*:

In the past month how often has your eyesight made you concerned or worried about…

	Not at all	Hardly at all	A little	A fair amount	A lot	Can't do because of eye sight	Don't do this for other reasons
Crossing the street?	0	1	2	3	4	5	8
Preparing a meal for yourself?	0	1	2	3	4	5	8

PLEASE START HERE AND REMEMBER:

Put one circle on each row. Please do not leave any rows blank.

In the PAST MONTH, how much has YOUR EYESIGHT INTERFERED with the following activities:

	Not at all	Hardly at all	A little	A fair amount	A lot	Can't do because of eyesight	Don't do this for other reasons
LEISURE & WORK							
1. Paid or voluntary work?	0	1	2	3	4	5	8
2. Favourite pastimes or hobbies?	0	1	2	3	4	5	8
3. Ability to enjoy TV?	0	1	2	3	4	5	8
4. Sporting activities such as bowling, walking or golf?	0	1	2	3	4	5	8
5. Sports events, movies or plays?	0	1	2	3	4	5	8
CONSUMER & SOCIAL INTERACTIONS							
6. Shopping?	0	1	2	3	4	5	8
7. Reading ordinary size print?	0	1	2	3	4	5	8
8. Visiting friends or family?	0	1	2	3	4	5	8
9. Recognising or meeting people?	0	1	2	3	4	5	8
10. Getting information that you need?	0	1	2	3	4	5	8
HOUSEHOLD & PERSONAL CARE							
11. Looking after your appearance?	0	1	2	3	4	5	8
12. Opening packaging?	0	1	2	3	4	5	8
13. Reading labels or instructions on medicines?	0	1	2	3	4	5	8
14. Operating household appliances and the telephone?	0	1	2	3	4	5	8
MOBILITY							
15. Reading a sign across the street?	0	1	2	3	4	5	8
16. Getting about outdoors? (on the pavement or crossing the street)	0	1	2	3	4	5	8
17. Go carefully to avoid falling or tripping?	0	1	2	3	4	5	8

18. Interfered with travelling or using transport?	0	1	2	3	4	5	8
19. Going down steps, stairs or curbs?	0	1	2	3	4	5	8

	Not at all	Very rarely	A little of the time	A fair amount of time	A lot of the time	All the time
GENERAL						
20. Your general safety at home?	0	1	2	3	4	5
21. Spilling or breaking things?	0	1	2	3	4	5
22. Your general safety when out of your home?	0	1	2	3	4	5
23. Stopped you doing the things you want to do?	0	1	2	3	4	5
24. Needed help from other people?	0	1	2	3	4	5
REACTION TO VISON LOSS						
25. Felt embarrassed because of your eyesight?	0	1	2	3	4	5
26. Felt frustated or annoyed because of your eyesight?	0	1	2	3	4	5
27. Felt lonely or isolated because of your eyesight?	0	1	2	3	4	5
28. Felt sad or low because of your eyesight?	0	1	2	3	4	5
29. Worried about your eyesight getting worse?	0	1	2	3	4	5
30. Concerned or worried about coping with everyday life?	0	1	2	3	4	5
31. Eyesight interfered with your life in general?	0	1	2	3	4	5
32. Felt like a nuisance or a burden because of your eyesight?	0	1	2	3	4	5

15 Appendix H

Self-Report of Function Questionnaire

Post Programme Follow-up

Pilot Project

Royal New Zealand Foundation for the Blind

Office Use Only			
ID			
Age			
Gender			

1 Participant Mem Number

2 Age: _____

3 Gende   Male   1

           Female   2

4 **Not require post Progra survey**

5 Have y lost an vision s the last survey'   Yes   1

         No   2

6 If so, h much usable vision you sa have now?   None   1

         A little   2

         A Lot   3

SECTION A – DEMOGRAPHICS

7 Has yo living situatio change   Yes   1

         No   2

since th
last sur

8 If yes, you **no** live

Alone	1	Live	
With spouse or other family member	2		
With others in house or flat	3		
With others in hostel, nursing home or residential care facility	4		

9 **Not required in pos programme survey**

☐

SECTION B GENERAL HEALTH (VFQ-1)

A 1 E

1 In general, would you your overall health is

NZ 2
Mac

Excellent	1	VFQ1C	☐
Very Good	2		Pac 4 Isla
Good	3		Oth 5
Fair	4		

Poor   5

SECTION C DAILY LIFE (IADL)

	In my Daily Life, I am …	Definitely True	Mostly True	Not Sure	Mostly False	Definitely false	Office Use Only	
11	Using my remaining vision effectively.	1	2	3	4	5	ADL1C	
12	able to read what I want.	1	2	3	4	5	ADL2C	
13	able to communicate with writing, typing, Braille, or tape recording.	1	2	3	4	5	ADL.3C	
14	capable of preparing my own meals.	1	2	3	4	5	ADL4C	
15	able to take care of daily needs: personal care, housekeeping etc.	1	2	3	4	5	ADL5C	
16	often leaving my property and walking without help.	1	2	3	4	5	ADL6C	
17	able to walk with safety and confidence	1	2	3	4	5	ADL7C	
18	able to orient myself and know where I am going.	1	2	3	4	5	ADL8C	
	In my Daily Life at home, I am …							
19	willing and confident to attend social engagements and interact with others	1	2	3	4	5	ADL9C	
20	enjoying my hobbies	1	2	3	4	5	ADL10C	

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and leisure activities

| 21 | able to work effectively with my hands on small (fine) tasks | 1 | 2 | 3 | 4 | 5 | ADL11C | |

| 22 | able to help with chores around my home | 1 | 2 | 3 | 4 | 5 | ADL12C | |

| 23 | an asset to my family and to my community. | 1 | 2 | 3 | 4 | 5 | ADL13C | |

24 In the last two months, I would consider myself to have been lonely

Not at all	1	LonliC
Moderately	2	
Severely	3	
Extremely	4	

SECTION D QUALITY OF LIFE (QOL)

25 In the last two months, I would say my overall quality of life has been:

Excellent	1	QOLC
Very Good	2	
Good	3	
Fair	4	
Poor	5	

SECTION E Peer interaction

26 I have a friendly chat with people who are not part of my immediate family either in person or on the phone or internet during a normal week?

Never	0
Seldom	1
Regularly	2
Often	3

27 How satisfied are you with this level of interaction

Extremely low	0
Low	1
Moderate	2
High	3
Extremely high	4

16 Appendix I

I. **High-level national VA personnel**

Questions:

1   What is your position within VA and what responsibilities do you hold pertaining to the client service model implementation?
2   Were you associated with any of the pre-merger organizations before the formation of Vision Australia (VAF, RVIB, RBS)?
3   What was your role in the establishment of the VA client service model?
4   How would you define client outcomes and do you think that the current service model is conducive to optimized client outcomes?
5   Have any significant changes been made to the service model?
6   What is the purpose of the Regional Client Committees and how do their roles differ from the Client Representative Council?
7   How does Vision Australia obtain feedback and outcomes information from its clients? Do all clients experience the same evaluation modules? Have any surveying techniques proven to be more effective than others?
8   What does Vision Australia do with the feedback it receives? Is this information readily available to this project team?
9   Are there any resources pertinent to the current client service model, the client feedback and evaluation techniques of VA, or previously evaluated client outcomes that are only available internally?
10 In your association with the pre-merger organization, what methods did you use for client outcomes assessment? Which methods did you find of particular use? Which ones did you gain nothing from?
11 In your association with the pre-merger organization, what service delivery model did you use? What services were offered? Are any new in from the VA merger?
12 What do you like and dislike about the current service delivery model and its implementations?
13 What are the working groups specifically designed to achieve? Are they fulfilling their objective? What would you like to see changed?

II. **Local VA Personnel**

Questions:

1   What is your position within VA and what does that position entail? Do you interact with clients in your line of work?

2   Were you associated with any of the pre-merger organizations before the formation of Vision Australia (VAF, RVIB, RBS)?

3   As our project is focusing on two parts, the first being a framework for the client service model, and the second being suggestions for evaluation leading to the optimization of client outcomes, we need to determine the amount of data collection that takes place on a day to day basis. To what extent do you interact with the clients

directly? When you meet with them, do you find that informal feedback from the interaction is more helpful than formal-written evaluations?

4   How often do you currently evaluate client outcomes? Do you collect information only informally or is the data from the interactions available for our project team to view? Do you have any suggestions for making the evaluation methods more conducive to both clients and the organization?

5   Having dealt with clients on a day-to-day basis, can you provide any suggestions for evaluating client outcomes that are both convenient for the client and helpful to the organization?

6   How would you define client outcomes and do you think that the current service model is conducive to optimized client outcomes?

7   What is the exact purpose of the client journals? Can VA personnel access these materials to gain insight regarding client outcome or are journal entries private?

8   How does Vision Australia obtain feedback and outcomes information from its clients? Do all clients experience the same evaluation modules? Have any surveying techniques proven to be more effective than others?

9   What does Vision Australia do with the feedback it receives? Is this information readily accessible?

10 Are there any resources pertinent to the current client service model, the client feedback and evaluation techniques of VA, or previously evaluated client outcomes that are only available internally?

III. **Client focus groups**

Purpose: Focus groups have been established in an effort to fulfill a main goal of this project, to develop a framework for evaluating client outcomes that is conducive to a cycle for continuous improvement. Client outcomes definitions obtained through these focus groups will be compared to those definitions provided by service personnel and upper management to determine discrepancies in client outcomes for service provision. In addition, understanding the outcomes assessment techniques that the clients prefer will aid in the development of a framework for outcomes assessment because suggesting client-preferred outcomes assessment techniques will result in qualitative outcomes information.

Target groups: elderly clients from the VAF pre-merger model and middle-age clients form the RVIB model.

These focus groups will take place over about only a half hour as the purpose of the groups is self-help, an issue that takes precedence over the studies this group conducts.

Scripted Formatting:

Individual introduction of Adam and Scott to the group:

- Adam remarks that he will be taking notes throughout the meeting

- Scott asks the group to introduce itself while Adam records the name and location of each participant in the group

Question 1: What were the goals of the services you received?
Question 2: Did you accomplish those goals?
Question 3: How did accomplishing these goals change your life?
Question 4: (Explain what Vision Australia wants to know to better serve its clients) What is the best way for us to get feedback from you?

Scott and Adam thank the group members for their help and the self help meeting commences.

17 Appendix J

Interview Transcripts

I. Interview with Dianne Awad
Interviewee: Dianne Awad
Interview conducted on: March 29th, 2007
Position in organization: Orthoptist in the Heidelberg office (RVIB)

Summary: This is her first job out of graduation from college about a year ago. She has some clinical experience from her college years. Her current job as an orthoptist is to receive referrals from the service coordinator, and then assess the client's visual situation to make recommendations about things like what sorts of magnifiers the client should use, and where the client should position themselves with respect to light so that they can get the most out of their sight. She also does vision loss assessments to determine the client's level of vision and assists them in learning how to use any remaining vision they have. She has no pre-merger affiliation. She had no suggestions in terms of outcomes assessment practices but does hope that the new client service model will not have orthoptics spread to thin over the organization.

Question 1: How would you define a successful outcome in terms of your line of work?
- Basically, any client that meets their goals is a client that has a positive outcome. She receives a list of those goals from the service coordinator.
- Such goals can be anything from being able to read the mail to continuing hobbies. In a general sense, getting the most out of their sight.

Question 2: Do you do anything in your normal line of work that might be related to assessing client outcomes?
- She does ask the client at the end of the service provision whether or not she has been helpful.
- Such discussions are definitely informal and clients seem to prefer that, although it is probably difficult to get useful negative feedback when the person asking the questions is the one that has established a relationship with the service provider.

Question 3: Is there anything you do in your daily routine that would lend itself to client outcomes assessment? Do you have any suggestions about how the organization might integrate outcomes assessment into normal service provision?
- Nothing really to add

Question 4: Is there anything that you would like to see implemented in the new service model that would make outcomes assessment easier integrate?
- Subjective refraction tests are a good way to ensure that clients, especially the elderly, have up to date glasses so that they get the most out of the services they are provided.

Question 5: Do you have any concerns or worries about the implementation of the new service model? Anything you would like to see added?
- No particular worries about the new service model. Hopes orthoptist services don't become limited and spread over a range of different people that don't specialize in orthoptics.
- She could not give any specific examples of where that sort of thing might happen.

II. Interview conducted with Kristy Cameron

Interviewee: Kristy Cameron
Interview conducted on: March 27, 2007
Position in the organization: Occupational Therapist in the Heidelberg office (RVIB)

Summary: Kristy has a B.S. In Physiology and Psychology as well as an M.S. in Occupational Therapy. She has been an Occupational Therapist with VA for 2 years. Before the merger, she worked under the RVIB service model. She currently works with clients between the ages of 3 to 100 years old assessing their ability to complete everyday tasks both domestic and with in their community. Though she does not use a tool currently, Kristy does want to see service coordinators follow up with clients on a timelier basis and to discuss in more detail the effects of the received services. In terms of the client service document, Kristy is worried about the over use of volunteers and how that will effect service provision as well as if the organization is spending too much of its time listening to clients and not enough time listening to the staff.

Question 1: What does your position entail fully? How do you do outcomes assessments in your specialty?
- Before service provision starts, she determines what the client's goals are, be it the ability to use a microwave or the stove. She must determine whether or not they should even be using the stove before she can teach them how to do it with vision impairment.
- The client outcomes she deals with are mostly task based.
- Service coordinator does follow up phone calls every three months to ensure everything is still fine and that the client doesn't need anything else. The client does not necessarily need to have an open case file to receive these calls.

Question 2: How do you conduct your assessments and service provision? Do clients seem to prefer an informal or more formalized setting? Do you have a standardized tool for developing the goals during these meetings?
- She conducts informal discussion with the clients and that is what they seem to prefer. She does not use a standard rubric to help determine the clients goals.

Question 3: During your time at VA and in the pre-merger organization, were you made aware of any tools used by the organization for outcomes assessments? Do you use any tools in your daily work?
- She is not aware of any specific client outcomes assessment tools used in the past by VA. She has definitely thought about the importance of client outcomes as it relates to OT.
- OT has no standardized outcomes or post-service assessment tool. Assessment of the completion of the goals laid out in the pre-service stage is done differently each time.
- There is an assessment tool available to Occupational Therapists known as the Canadian Occupational Performance Measure. It isn't used very much because the numerical scale is confusing and complex for the client, and it is time consuming to use and teach.
- The assessment tool has 20 or so questions that deal with the client assessing their own ability to complete daily tasks. It is usually done pre and post service provision.

Question 4: Do you have any suggestions on how to conduct outcomes assessments more methodically and with standardized results?
- Service coordinators could pursue actual outcomes more actively.

- Sometimes the question asked in the follow up phone calls is about what else the client may need, rather than how the service has changed the way they are able to live their lives.

Question 5: If you have read the new client service model document, what are you excited about or what do you have reservations towards?
- The use of volunteers in the new service model may be too frequent. Volunteers need to be directed by the professionals. They need to understand that they may not be able to do the job by themselves.
- The importance of what the staff are saying should be reiterated. The clients are a very important part of how the organization runs, but the staff usually know more about what goes on behind the scenes.

III.   Interview with Graeme Craig
Interviewee: Graeme Craig
Interview conducted on: March 29, 2007
Position in the organization: Senior Manager of Service Delivery in Kooyong (RVIB)

Summary: Graeme originally began as an O&M and steadily moved up until his current position of Senior Manager of Service Delivery in VA. He has a Masters in Human Services Management. He is the head of a design group centered on outcomes assessments at a qualitative level as well as continuous improvement for both client and organization. To do this, he will use our project to address the group and run with the ideas offered as well as to help point out areas that need to be addressed within the entire organization. He pointed out that VA needs to know if the main goals set forth in the service model document have been/ will be/ or can be implemented across the organization in the future as well as a tool that assesses client outcomes without adding additional strain on the client during the intake and service provision processes.

Preliminary Question 1: As we conduct focus groups with the current clients of VA, are there any types of information that the senior board would like to hear directly from clients concerning outcomes assessment or the new service delivery model?
- Nothing in particular that he can think of
- Would be interesting to see what clients view as a successful outcome and how that compares to what service provision personnel believe to be a success
- They would like to see how the clients articulate the concept of outcomes—is it task based or quality of life, etc
- In the past the organization has looked at goals and the attainment of those goals— found that it is difficult for the clients to actually articulate what has and has not been attained without being subjective

Preliminary Question 2: In terms of the implementation of the client service model and its evaluation, can you clarify what it is you and the board want to see from this project.
- The model document is entirely a framework—it explains what will be done but not how
- Outlines the key principles that they want to see in the organization—the main issues not necessarily the task oriented options
- The board wants to determine if the key parts of the model have been implemented

1. Ex. In the model document there is a noticeable shift from centralized to regionalized specialties
2. Ex. The concept of the key worker and its role as well as where and how it has been implemented
3. Ex. The organization wants to offer more widespread and uniform services are they?

- Concrete examples of implementation are easier to find and not want the executives want to focus on. Look more at goals of the original document
  1. Re-read document and determine original goals set forth
  2. Use those goals and ask questions as to if they have been met, how they have been met, what problems they came across in putting it into affect
  3. Come up with suggestions on how to implement better

Preliminary Question 3: We understand that the action teams are a new development. Why were they created and what are they setting out to do for VA?
- Important to evaluate interdisciplinary services like Education or Independence in the Home. These themes require more than one provider to accomplish all aspects
- Important to look at outcomes not on a specialist by specialist approach but rather a complete theme
- Teams themselves are multidisciplinary and are determining appropriate outcomes for their particular theme and not specialty based

Pointed out by Graeme before interview began:
- Important to have both quality of life as well as task based concepts of outcome assessments because VA deals with both aspects
- Want the assessment procedure to not be additional process but just incorporated into the normal flow of intake and service provision

Question 1: What is your background in general and with the pre-merger organizations?
- The pre-merger organization affiliation was with RVIB
- Originally Deputy General Manager of Client Services
- First began as an O&M
- Has a Masters in Human Services Management
- 20 years total in the field of vision loss
- 10 years were spent with RNZFB
- Became Senior Manager after interim position last year

Question 2: We know that you are on a specific Design group. Was there a specific reason that you chose the one you are on?
- As the Senior Manager of Service Delivery he is responsible for the implementation of the model and the concept of continuous improvement

Question 3: Have the design groups developed any goals yet? Do they have concepts of what they want to do in terms of the service delivery model?
- Graeme's particular group are going to use our project to feed into the work of the group
- Design group will be informed of our work and suggestions and then take those and use them

- Want service provision to consider quality of life as well as what it is they individually and specifically do
- Wants to consider what each person believes to be an outcome as well as positive outcomes in general
- Budget currently can't take into account actual outcomes—no quantifiable way to deal with qualitative data

Question 4: What is an outcome and a successful outcome at your particular level in the organization?
- Goals are still important but there is an issue currently with how staff define goals with clients
- Want higher levels of goals beyond detail of can you work a toaster or see the stove
- Wants the broader concepts to be considered—what does a toaster accomplish in the broader spectrum of quality of life
- Wants to consider quality of life as well as goal attainment

Question 5: What does the organization do with outcome data it receives?
- Currently no analysis done with outcomes since that hasn't been incorporated into the funding necessities yet
- As of right now only information gathered and used is number of hours in any given area, number of services, number of intake, number leaving
- Board wants quality of life information that right now is only given with the quantitative numbers and on case study basis

Question 6: As we look at suggestions for you in terms of outcomes assessments, what would you like to be included?
- Try to get information concerning each suggestion not just from who created it
- Avoid bias
- Use numbers to back up the suggestions
- Vision Australia also needs to know about the tool and how to use it!
- Intake can be done over the phone or in person and the tools must be applicable in any method
- Necessary to have a quality of life measurement so that the board and the organization can determine what the client is actually interested in.

Question 7: Have there been post-assessments done for outcomes assessments in the past?
- Not since pre-merger organizations existed
- Not sure how widespread any one attempt was

Question 8: The original document consisted of actual models in the new service model but now has been changed to themes. Why was this done?
- Organization wants to move away from service specific and toward broad areas of client need
- Look at the larger needs and issues that more than one specialty need to partake in
- Hope it provides to clients better idea of what services are offered—ex. Clients may not know what an O&M is but they will understand Independence in the home
- Clients also felt that it was becoming difficult to get information about services
- Directory thus created to present modules to clients in way they understand them better and can chose for themselves more

Question 9: How will the directory be provided to clients?
- Will be a function of the website
- Hope to keep it more interactive
- Help to clarify resources to both clients and staff

Question 10: Action teams were created in the new client service model but why?
- Determine key steps to provision of any service from all of the pre-merger organizations in the specific specialties but also in broader terms
- Main goals to be created in a module area
- Get everyone on the same page to help create uniform provision across the organization
- Hopefully all goals and meanings available in September

Question 11: Do the Design Groups have a document available to read like the action groups do concerning the purpose and necessary steps?
- No
- Graeme will send what basically the groups are working on
- Looking more at the process and less on specific information
- Outcomes from one design group to the next will be different based on their area
- Have to define the issue that they are looking into
- Helpful to talk to the design group leaders

Question 12: Who are the main design group leaders we should try to get in touch with?
- Ian Moore and Chris Edwards
- Action teams are more responsible for the gathering of service information
- Design groups look at process information

Question 13: The action teams are making outcomes for their particular areas of the model. What will the CSM8 do with it?
- Action teams have no management input
- CSM8 will first check to see if there is consistency in all areas and in all teams
- Then will address actual outcomes across the 55 teams
- Senior management will decide if outcomes they created are cohesive with main goals of the service model. Revision will happen if there are inconsistencies

Points of Interest:
- Graeme has data on the International low-vision conference held in London
- Get contact information for Adrian Henderson from Graeme concerning RNZFB
- Contact Genevieve Napo to get optometry resources help

IV. Interview with Mary Curnow
Interviewee: Mary Curnow
Interview conducted on: March 26, 2007
Position held in organization: Newly hired O&M at Boronia/Mitcham offices (No pre-merger affiliation)

Summary: Mary Curnow has recently been hired by Vision Australia to fulfill the role of O&M in the Boronia office that also incorporates the Mitcham staff. This will be her first job

as an O&M though she worked with adults with varying disabilities in a recreational setting in the past. After taking a course to become an instructor for the visually impaired, she took a placement test at the then VAF office in Kooyong one and a half years ago. Mary noted that though her original schooling was conducted based on similarities with the RVIB model, the experiences she had with clients was done following the VAF model. To Mary's recollection, the only form of assessments in terms of client outcomes done at Kooyong were follow up phone calls at the termination of service provision. Also, Mary would like to specialize as much as possible in only O&M instead of also being a service coordinator as it helps to hone the skills when more time is spent in one area.

Question1: What will your position be at the Mitcham/Boronia dual office?
- Hired as an O&M
- First job to do so
- Previously worked with adults having disabilities in a recreational setting
- In the States, worked as an instructor for snowboarding and skiing
- From there took a course specifically for instruction to visually disabled individuals

Question 2: When you were at Kooyong for the placement test and your original work with clients, did you ever notice Vision Australia performing outcomes assessments on the clients at the end of service?
- Mary remarked that Kooyong seemed to still use the VAF model of service provision
- At the end of the provided service with a specialist, the case would be passed on to any remaining specialists offering further services.
- At the final completion of the case from all specialist areas, the case was handed to the service coordinator of that particular client.
- At some point following the end of the case (a few weeks or months after-Mary was unsure) a follow up call was made to determine satisfaction, outcomes, if any further services would be helpful in the future.
- Main goal seemed to be general satisfaction ideas and keeping contact

Question 3: In terms of the new client service model, have you become aware of anyone's concerns about its implementations? Anything you or they are happy about?
- She hasn't looked into the actual document as a recent hire
- Wants to focus on initial O&M section first before looking elsewhere

Question 4: Even though you haven't put into practice work as an O&M yet, based on your schooling and your hopes, would you prefer to concentrate only on your specialty and have someone else be the service coordinator or would you like to do both?
- Mary thought that it is very important to specialize in your field
- More time spent working on it, the better the skills become and ultimately the better the service.
- Preferably would be to just work as the specialist but Mary herself remarked that wouldn't mind a light load of service coordination. (One day a week)
- She likes doing small things at that time (like marking a stove) if that is all that is needed rather than involving a whole different pathway, but sees where the problems can come about based on understaffing and client numbers.

V. Interview with Lynn Dalmazzo
Interviewee: Lynn Dalmazzo

Interview conducted on: March 30, 2007
Position in organization: Orthoptist and Team Leader in Coffs Harbour (RBS)

Summary: Lynn Dalmazzo was originally an orthoptist and is currently a manager of the Coffs Harbour office. She currently implements a questionnaire like that of Canberra that is distributed to clients before the first meeting. The aim is to identify main goal of the individual as well as areas they need to work on. The problem she has with the use of the questionnaire is that it does not always eliminate bias and it does not always look at broad areas of concern but rather services offered by the individual specialties. Her main concern with the service model is that it still allows for home visits as was used in the RVIB model and she believes that is not the most effective use of time.

Question 1: What is your background with the organization and what is it you do on a daily basis?
- With VA for 16 years
- Team Leader of Coffs Harbour for 4-5 years
- Manager since Feb

Question 2: What was your pre-merger affiliation? Did you just have one or did you move around?
- Always has been with RBS

Question 3: How would you define a successful outcome in your specialty?
- Identified needs are met and the needs decided upon are realistic to the client's abilities
- Sometimes the simplest solution is not the best and more than one specialist may have to become involved
- Outcomes indicated by the client have to be reevaluated because of differences from one individual to another

Question 4: Do you speak with clients about outcomes on a daily basis? If so how? If it is informal do they tend to prefer this method?
- Informal assessment is done but is based on the questionnaire provided to the individual before the first meeting
- Questionnaire helps to identify all issues that the client may have a problem with

Question 5: Are you able to suggest strategies for client outcomes assessment that would be easily integrated into the system?
- Very difficult to assess client outcomes
- In the past it was noticed that the wording of questions shouldn't always be based on the pre-service assessments
- Needs can change from the beginning of service to after service provision

Question 6: Do you know of any specific outcomes assessments done by VA in the past?
- They use a questionnaire at her office
- Problems with the questionnaire are that they are not always filled out by the client and even though an area is present to say that a relative filled it out, not always done introducing bias and second parties

- Also not always tailored to the greater needs of the client but can sometimes be restricted to just one specialty

Question 7: Do you have any concerns with the new client service model? What do you think would indicate it has been successfully implemented?
- No real concerns about the implementation of the model
- RBS offices are used to a more centralized offering of services
- RVIB does home visits but they can't do as many as needed
- Distance is a factor and should be considered
- Believes that going to the clients home as Victorian offices do is not a using time effectively
- Believes possible to simulate home setting in the clinic and accomplish more for more people

VI. Interview with Renata De Lazzari
Interviewee: Renata De Lazzari
Interview conducted on: April 18, 2007
Position in organization: Orthoptist at Kooyong

Summary: Renata De Lazzari was formally trained as an Orthoptist and worked with the Association for the Blind in Western Australia with all different types and ages of client. She came to Vision Australia from the VAF model, during the transition into a merged organization. She believes that the most basic form of client outcome is the clients understanding of their limitations and their vision impairment. She always uses an informal discussion to speak with clients about what they want out of their services and what might be bothering them at the time of entry. She thinks functional vision assessments are a good way to gage client ability and to determine if the outcomes the client may want are physically feasible. She lists several thing that used to be done to assess a clients progress or needs after the services have been provided, and she also believes that the current client service model document provides no insight into how the model will be integrated into the organization. She also thinks that successful implementation of the client service model means that a new staff member can easily understand how things are done shortly after entering the organization. Also, client intake should involve a standardized tool for client record keeping and a standardized databased that those records can be stored in.

Question 1: What is your background in the organization and what do you do on a daily basis?
- Formal training in Orthoptics, finishing a masters degree in management.
- Started working in a clinic run by the Association for the Blind in Western Australia dealing with clients of all ages. Was a team leader there about a year ago.
- She now serves all the capacities of an Orthoptist, namely, prescribing magnifiers and teaching clients how to use them. Also, she teaches clients how to use their remaining vision and how to use light to their advantage.
- She has been working with blind clients for about 9 years, going on 10 years.

Question 2: What is you pre-merger affiliation?
- It would be considered VAF but she came in right as the organization was transitioning into the merger.

Question 3: How would you define a successful client outcome from the perspective of an Orthoptist?
- At the most basic level, a client should come away with a good understanding of their vision impairment.
- Any other skills that the client learns is in addition to that basic level of understanding, but the clients knowledge of their impairment and their abilities is most important.
- Another very important outcome is that the client understands that they can have access to the services they want at anytime, and that they know how to access those services.

Question 4: Do you speak with clients about what sorts of outcomes they would like to have? Is it an informal discussion?
- Not specifically about client outcomes, but she asks them about what they would like to do with the services and what is bothering them in the first place.
- She confirms what they want with what is bothering them, that way it is easy in the end to determine whether or not the outcome was successful.

Question 5: Can you suggest anything that may contribute to the assessment of client outcomes given what you already do as an Orthoptist?
- Functional vision assessments are a good starting point to help determine what further service should be provided to each client. This assessment is an essential part of determining the service pathway of the client because it shows what they can do and what may be less feasible.
- It is useful for determining client outcomes because it gives insight into whether or not future outcomes are likely to be successful because there is an understanding of the client's physical limitations.

Question 6: Do you know of any specific client outcomes assessments used by Vision Australia in the past?
- Used to give a list of clients to a group of volunteers. Those volunteers called those clients and conducted a survey dealing with their current condition and the nature of any further services required. The survey was part of government funded disabilities services.
- Team managers also used to do random client case evaluations by calling clients randomly to determine of the services they had received actually worked for the client and whether or not the client required further services.
- As part of what is done when a client enters service provision, staff sit down with the client and agree on the clients service pathway such that the client receives the most appropriate services for their issues.
- When service is terminated, clients are asked what else they need and whether or not the services provided helped them live.
- This information is always documented in client case files.

Question 7: Do you have any concerns about the new client service model? What do you think would indicate successful implementation of the new model?
- Right now, the biggest concern is how it will all be implemented. The document provides no insight into how the service model will actually be integrated into how things are run. When the actual service modules come out, it should clear up most of that ambiguity.
- The service model had been implemented successfully if a new staff member can

come into the organization and understand how things are done easily within their training period. If a staff member can;t do that, then it will be difficult for any client to be able to understand what they can do with their services at Vision Australia.

Question 8: How important is a standardized client intake process and what needs to be done to get one in place?
- A standardized database needs to be created and used by all parts of the organization.
- There needs to be a standardized tool used by everyone within the organization to record client files.
- Each level of the organization needs to understand that this basic level of standardization needs to be followed in order for the rest of the organization to run properly.

VII. Interview with Chris Edwards
Interviewee: Chris Edwards
Interview conducted on: April 18, 2007
Position in organization: Senior Manager of Partnerships

Summary: Chris Edwards is Senior Manager of Partnerships. He deals with partnerships between Vision Australia and all manner of agencies and organization that could help or complement the services that Vision Australia provides. He was originally with RVIB. He thinks there are two levels of client outcomes, the first of which is more immediately obvious and the second warrants more thorough investigation by the service provider. To actually achieve client outcomes assessment, Chris thinks there needs to be a service provision plan with the client at the start of service, then the achievement of the clients goals should be assessed by the service provider. A representative sample may be the best way to collect more qualitative outcomes assessment information. Chris also mentions the training undertaken by the Prahran office to look at assessment of client outcomes, however, the questions asked do not seem to be very focused on outcomes. Chris also mentions several things that would indicate successful client service model implementation. To Chris, the most important part of the new client service model is client choice, such that the client feels empowered with the service they are to receive. Chris also mentions the shift in funding from blocks of money to more individualized sums based on things like number of clients successfully served.

Question 1: What is your role as Senior Manager of Partnerships?
- Develops relationships with government agencies, the educational sector and any other organization, for-profit or not-for-profit, that could provide services that may complement those of Vision Australia.

Question 2: What was your pre-merger affiliation?
- RVIB

Question 3: What is your idea of a successful client outcome?
- There are two levels, the first is determining what the client's goals were in the beginning, and the second is whether or not the services made a difference in the client's life. The first level is more immediately obvious, and the second requires special attention on the part of the service provider.
- An example is whether or not the client learned to touch type? If so, how did the ability to touch type effect my life?

Question 4: Do you have any suggestions about how client outcomes assessments should done?

- Some sort of service plan should be constructed with the client from the start. Then the achievement of those goals should be assessed by the service provider.
- A representative sampling may need to be taken and surveyed in detail in order to obtain true client outcomes information rather than the quantitative achievement of goals.

Question 5: Have there been any outcomes assessments used in the past by Vision Australia or any of the pre-merger organizations?

- The training program in Prahran looked into the assessment of client outcomes.
- Mostly, the question was about the achievement of goals and whether or not the client was satisfied regardless of whether or not the goals were actually achieved.

Question 6: What are some indicators of successful implementation of the new client service model?

- The provision of services is common across the organization.
- There should be a common intake method for all clients.
- There should be a standardized service provision guide for staff to follow.
- There must be standardized training surrounding all service modules.
- Quality of life and outcomes assessments should be in place across the entire organization, and the data collected should be put to good use.
- Services should be offered as a good mix of centralized, regionalized and outreach access.

Question 7: What are the most important parts of the new service model?

- Client choice is the most important aspect of the new service model. Client intake is also important, but the client needs to feel empowered to select the service they choose.

Question 8: How important is outcomes assessment in terms of funding?

- The new trend is to look at services in terms of their impact on the client's life. Money provided by funders, including the government, is linked to individual clients. So simply put, each client served successfully represents a certain amount of money for the organization.

VIII. Interview with Jane Ellis

Interviewee: Jane Ellis
Interview conducted on: March 23rd, 2007
Position in organization: Senior Manager in Region 4 at Enfield (RBS)

Summary: Jane Ellis has been with the VA organization as well as the RBS pre-merger organization for the past 15 years. She started in the organization as an orthoptist and eventually became promoted to Team manager and then Manager of Client Liaison Service followed by Manager of Centralized Operations, and finally Senior Manager of Region 4. She works on a design team with Graeme Craig and looks at the overall feasibility of implementing the new model for service delivery. She also explained that outcomes from her standpoint do not always have to come from the VA interaction of services and products. It can also incorporate a general understanding of the low-vision condition and its limitations as

well as where it is no longer the limiting factor. She explained the idea that someone wanting to knit but having low-vision may at first only blame the vision loss for the inability to knit. However, a good outcome would be to offer a magnifier and have the client again attempt the activity. If then they see that arthritis is the limiting factor, the outlook on life may be different for the client since they see that their vision loss is not always the problem and can often times be over come. Finally, though no outcomes assessments are currently in place to her knowledge beyond the surveying done without her knowledge, she was aware of the RBS method employed in the past. In that particular method post-assessment surveys were given to clients and investigated complaints as well as suggestions, following of policies and procedures by the organization, and general questions relating to equipment. When discussing the new client service model, the only worry she had related the amount of time needed to fully implement the model and the amount of resources it required.

Question 1: What is your general background with Vision Australia and the pre-merger organization?
- Working with VA for the past 15 years
- Originally worked as an orthoptist in Orange, New South Wales
- Team leader for 7 years
- Moved to Sydney and became Manager of Client Liaison Service for 5 years
- Then became manager of Centralized Operations
- Additionally was Team Leader for Employment, Technology, and Training
- Currently Senior Manager of Region 4
    1. Top half of the New South Wales State

Question 2: What are the purposes of the design teams and the action groups?
- She is on the project team heading design with Graeme
- The team looks at designing the flow of the service delivery model and how it works
- Ex. Client intake and the more specific process of service initiation
    1. How to determine if a client is eligible
    2. How long it takes to receive services
- Action teams are made up of service providing staff
    1. They look at areas where services are provided
    2. What specifically clients ask for
    3. Look at balance of resources
    4. Mix of professional backgrounds
    5. Mix of pre-merger organizations
    6. Very outwardly focused (clients)

Question 3: In your line of work within the organization, what do you see as an outcome? What makes it a positive one?
- The ability to look at quality of life both before and after services
- Outcomes may take into account an understanding of what the client wanted originally
- Possible outcome may be having the client understand their limitations and that it is not always the sight that is the problem
    1. Ex. A client wants to knit but is having trouble seeing. Receives a magnifier but still having trouble knitting. Real limitation is arthritis

Question 4: To your knowledge and in past experience, has RBS or Vision Australia implemented any kind of outcomes assessments?
- Currently there are exit interviews from Braille training along with an outgoing course center.
- Client surveying is going on in VA but she is unsure of the timing
- RBS had a post-service evaluation in place but it is no longer in use
    1. Asked customers about complaints/suggestions
    2. Whether any policies or procedures are known by the clients and their views
    3. Policies that run organization are supposed to be abided by at all times
    4. Equipment evaluation as well

Question 5: Have you or do you have any concerns about the new client service model?
- No real concerns
- Still noticed a lot of work has to be done
- The model will require a lot of resources
- The time frame in terms of actual implementation seems very vague

Question 6: What are working groups exactly?
- They are comprised of members of action and design teams
- They run across the entire organization in all client services
- They look at resource allocation and changes in overall infrastructure

IX. Interview with Dianne Epstein
Interviewee: Dianne Epstein
Interview conducted on: March 29th, 2007
Position in organization: Early Childhood Educator in Canberra office (RBS)

Summary: Dianne is an Early Childhood Educator and has been with the organization for 10 years total. She works with children and their families to offer services and products useful for the "normal" development of a child and entrance into the school system. She believes that outcomes assessments could easily be added to the last phone call made by the service coordinator and that a tool created to serve as a reference point would be helpful. She also believes that the OATs is a good idea in terms of providing more services to areas that are lacking currently due to staff shortages.

Question 1: What is does your position as an ECE fully entail?
- Works with children
- Determines their qualification and determines what they may need now and in the future
- If necessary offers or transfers their case to other specialties needed
- Initially conducts an interview to determine exactly where the child stands and the family
- Division into two streams of clients:
    1. Stream A: May include the other service providers in the office. Tends to be long term care or care that is on going.
    2. Stream B: Shorter term care usually. Usually takes care of these clients on her own
- The timeframe is determined by the client

- Services in the capacity to talk / act as a liaison with other organizations
- Usually runs team meetings

Question 2: How long have you been with the VA organization?
- Spent 10 years total with the organization
- 6 years in Enfield and 4 years in Canberra

Question 3: In your work, have there ever been any outcomes assessments done on a qualitative scale? Do you yourself do any?
- She wants to keep in contact with the family
- Keep updated goals for the family and the client in particular
- Reevaluates goals after 1 year if with a long term client or at the end of service provision if it is a short term client
- Goal review is performed by her and the goals and their outcomes are recorded and new ones are made if necessary
- The documents she keeps outcomes information on are sent to a different part of the organization who then calls the client and speaks in terms of the actual service provision and quality
- Information is relayed back to the service provider through generalities at team meetings

Question 4: How are outcomes assessed or made in your specialty?
- You look at the child's development and use that as a basis for outcomes
- Plotted according to her specialty and not usually by what family says

Question 5: Do you have any suggestions in terms of changes to the current service model or its implementation?
- The first call made to a client at input should be made by the councilor
- They should also have councilor go with ECE to interview because councilor is better at emotional state of the family and getting useful information and feedback

Question 6: Where do you think outcomes assessments should be done in the future and do you have any suggestions?
- The follow up call is already being done by the service coordinator
- It could be altered to include qualitative questions because the service coordinator deals with those topics everyday
- A tool could be developed as a basis of reference for that phone call and pertinent information

Question 7: Do you have any other suggestions or feedback concerning outcomes assessments or the new client service model?
- Need more staff
- Families are unable to currently get everything they need
- Need to look at other organizations that have regionalized in terms of support for specialists
- OATs team could be used more effectively
- Many staff changes wonders about consistency

X. Interview with Melanie Fischer

Interviewee: Melanie Fischer
Interview conducted on: March 22, 2007
Position held: Occupational Therapist in Boronia office (RVIB)

Summary: Melanie is an occupational therapist working in the Boronia office. Much like other OTs, Melanie believes that positive outcomes are when clients achieve the goals the choose for themselves. The use and training of volunteers in addition to the implementation of key contacts were discussed when the new service model was mentioned.

Question 1: What does your position, occupational therapy, entail?
- OT's see clients in their homes and assist in the performance of daily living activities
- OT's tend to perform odd tasks, essentially anything not covered by orthoptists and O&M personnel

Question 2: Prior to your involvement with Vision Australia, were you affiliated with any of the three pre-merger organizations? Was your role in the organization the same as it is now?
- She was a student studying occupational therapy that studied under RVIB; participated in short term internship-like studies
- Received a job just before the merger due to her relationship with RVIB

Question 3: In terms of occupational therapy, could you please describe client outcomes and provide an example?
- A successful outcome for OT's is when a client achieves the goals they set for themselves
- The goals are mostly client-based in that they choose goals themselves
- Melanie occasionally directs goals by suggesting smaller goals in pursuit of larger goals defined by the clients (i.e. independence, etc.)

Question 4: When you interact with clients is it always outcomes based?
- (Deviation from question) Clients generally prefer discussion based outcomes evaluation to surveys
- They can contact Melanie if new goals are desire new goals, contact broken off until then

Question 5: Have you had any past experience with outcomes assessment? Do you have any suggestions about additional assessment techniques?
- Melanie hasn't heard of any reviewing period of her clients, VA allows for autonomous judgment—they trust the trained personnel.
- It is possible for the service provision personnel (i.e. Mark) to perform a case review to see if the client needs further service, but that is rarely performed to her knowledge

Question 6: Do you have any suggestions or concerns regarding the current service model document and its planned implementation?
- Melanie has a few concerns that others have mentioned. The ex-RVIB OT's meet and feel as though some of the appendices contradict the main model document
- The presence of OT's, their exact role and structure of their importance, is not mentioned in much detail in the model. They are afraid that non-qualified personnel will be hired to do some OT work and not perform to the level of an OT.

- Prefers service managers to key contacts, because making every specialist into a service provision position will take away from their actual job
- Too busy with OT work already, can't handle service provision responsibilities
- There has been a lot of pressure placed on the volunteers, why should they be expected to have formal training and operate to the capacity of the current personnel.

XI. Interview with Jenny Gibbons

Interviewee: Jenny Gibbons
Interview conducted on: April 13, 2007
Position in organization: Manager in Mildura (VAF)

Summary: Jenny has been with the organization for nearly 10 years, generally the duration of service for most local managers. She had some new ideas about defining client outcomes and had an amazing comment on how Vision Australia can show its clients what the organization is doing with outcomes feedback. The Mildura office had positive feedback for the new service model, and the complaints were very congruent with those from other VAF service areas.

Question 1: Could you please provide some background information on your training and experience with the organization?
- 9 and a half years with the organization
- Started as a volunteer coordinator and became service manager
- Also possesses a teaching background

Question 2: How would you define successful client outcomes?
- Exceeding the expectations of the client and going that extra mile
- Goals also used, service pathway

Question 3: Do you personally discuss outcomes with the clients? Do you know of any outcomes assessment techniques used in the past?
- Mildura is a concentrated population and a small community
- Close connection between clients and Mildura staff
- Quality surveys were administered over the years, these were random selection and conducted by volunteers, it was more quality improvement

Question 4: Do you have any suggestions on how outcomes can be evaluated when the new model is implemented?
- Tricky—phone surveys are valuable to those that can't see
- Local phone calls resulted in positive feedback
- If all clients are administered outcomes assessment, the staff need to have the necessary skills, but the idea has real merit to it
- Radio and library service perfect for VA to relay outcomes information and what they plan to do with it
- Also good to analyze the broad scope of outcomes

Question 4: To what extent do you understand the new service model of VA and what are some suggestions you have about its implementation?
- Positive feedback in Mildura
- Whole of life approach very good

- OAT's make plenty of sense
- Key contacts already used, so that's also good
- Intake not much of a problem because that office is so small
- Intake issues sorted out easily, very few staff that are generally all familiar with clients
- Positive discussion about NCC (may, however, take away localness)
- Client intake should be kept as simple as possible for the benefit of the clients
- Very flexible—great aspect of the new model
- Not many anticipated changed for that office

XII. Interview with Beth Glover

Interviewee: Beth Glover
Interview conducted on: March 29, 2007
Position in organization: Early Childhood Education in Heidelberg office (RVIB)

Summary: Beth is an ECE (early childhood educator) at the Heidelberg office. She has been with the organization since 1980. Beth sees outcomes as a changing concept from family to family. The new service model document was relatively approved, however the extensive use of jargon was mentioned.

Question 1: What do you do as an ECE and do you have any direct interaction with clients?
- She has a number of clients in northern rural and city areas.
- Works with families that have children with diagnoses of vision impairment from the age of birth to school
- She will help in the home based setting or in the school
- Is a trained kindergarten teacher
- Performed many other services such as Braille teaching and counseling

Question 2: For how long have you been with the organization and what was your pre-merger affiliation?
- Has been with RVIB since 1980

Question 3: How would you define a successful outcome?
- Very difficult to have one set idea
- Varies from individual to individual and family to family
- The family should feel like they are in charge of the decisions
- Family should feel confident that they can either ask her for more services or tell her the services are no longer needed or not working
- Very developmental based and strives to have child reach their potential

Question 4: Do you personally discuss outcomes with the clients? Is it an informal setting? What do they prefer?
- Usually leave the family to begin services
- Try to deal with a family in any given situation based on motivational and emotional needs
- Proceed based on the families more so than any set plan
- Formal presentations are done to school staff that have interaction with vision impaired student
- Focus on the impact of vision impairment on a child

- Generally has an informal goal determination
- Occasionally set a set schedule with family in terms of achieving goals
- She will reevaluate intermittently during service provision

Question 5: Can you suggest strategies for client outcomes assessment that would be easily integrated into the new system?
- At the end of service provision, have something to compare what the situation was at the beginning of service provision to what was achieved at the end
- Help families keep track of the progress of their child
- Leave the families with information so she can always be contacted again
- She can't personally follow up with families after service provision ends because she has not additional time—too many other families to get to.

Question 6: Do you know about any specific outcomes assessments used in the past by VA?
- She was on a committee once doing outcomes assessments with Graeme Craig about ECE
- Assessed a certain case in which a child started to show development of sight—VA to have no further involvement but to make sure that other organizations are contacted and met with first

Question 7: Do you have any concerns with the new service model? What do you think would indicate its successful implementation?
- She read the document
- The language seems to be a problem—lots of "jargon" that doesn't make sense
- Wants the document to be easily read
- Approves of all the principles within the document and the new model
- Is worried about the use of volunteers with children—not trained well enough
- She wants there to be a large focus on specialization of vision impaired services and the ability to look at the individual cases to see the outcomes

X. Interview with Christine Harding
Interviewee: Christine Harding
Interview conducted on: April 2, 2007
Position in organization: General Manager of Client Services in Kooyong office (RVIB)

Summary: Ms. Christine Harding is the General Manager of Client Services and reports to the CEO of the organization as well as the Board. Before her 11 year experience with Vision Australia and the pre-merger organization of RVIB, Ms. Harding was a school teacher and principal. To her and those at her level, an outcome for a client is the achievement of goals set out at the beginning of the program. Ideally these goals are not just task based but also the larger quality of life questions. She currently only receives quantitative client information such as number of intake in a region, number of services provided, etc. There is no qualitative data provided and thus it is not used internally or during discussions concerning funding. There is currently no available tool that she knows of that would allow for the understanding of clients on a quality basis. When this informative tool is created, the organization plans to use it not only for funding, but to determine what areas of service or centers need additional training. They will also use the information to discuss with clients all of the aspects of the organization, what it offers, and the success rates it has had in the past. In terms of the client service model her main goal is to see it implemented as quickly as

possible while still staying effective. To her, the most important thing to have implemented is a standard intake method across the organization that from there the other goals can be laid across.

Question 1: What is your background in terms of the pre-merger organizations and your experience in general?
- Currently Manager of Client Services in Kooyong
- Was affiliated with RVIB
- Started in teaching—originally classroom teacher
- Became principal of a school
- Been with RVIB 9 years
- VA 2 years
- Total experience in organization 11years

Question 2: As the project is looking for outcomes assessments methods, what do you see as an outcome?
- Client is able to achieve the goals set out at the beginning of the program
- Ideally want their to be achievement at task based level and at greater quality of life level
- Ex. In terms of Independence there may be 3 tasks associated with that goal. Want to attain the 3 goals but also have that make for the attainment of the much broader goal of independence—everything works together

Question 3: At your level in the organization, do you currently receive any form of qualitative outcomes assessments?
- Only receive overall stats
- Numbers of new clients, number of services in a given area
- Only actual qualitative outcomes assessment done at this time revolves around planning of outcomes programs
- Nothing actually tangible is present
- Necessary for the organization to move forward and better what it is they are doing

Question 4: Why is there a new shift towards the entire organization being focused on more qualitative outcomes rather than quantitative as it has been in the past?
- Necessary for the organization to be aware of how the clients are doing in an organization of this size
- Want to focus on the quality aspect—it is an organization providing hopefully life changing services
- Need to see that the individuals providing the services are actually making a difference
- Be able to use the information to determine if outcomes are successful and if they are not why not? How can you fix it?
- Helps the organization to use money appropriately and get "the most bang for the bucks"

Question 5: When you do receive this qualitative information, what does the organization plan to use it for? Solely for the funding aspect or internally as well?
- Gives the organization the ability to report to the clients more accurate information about outcomes

- Provides information to present to board that can help with funding aspect (if they want to try to receive more) as well as seeing progress of entire organization
- Shows more distinctively areas that require more training for staff members to achieve the best outcomes
- Example—1 office having the lowest outcomes of the organization. Then the board and members would look into where the problem is? Why it is happening? How to fix the problem and any possible training situations?

Question 6: At your level in the organization, what were the main things that VA wanted to implement with the new client service model?
- Everything is important in the model and has a purpose
- The point that they want the soonest is to identify a common practice between the three pre-merger organization especially when looking at intake
- Want to get all 3 pre-merger organizations on the same page in terms of intake and basic processes and then from there overlay the other points in the new model
- Very difficult to get 500 staff in 35 centers to all implement at the same time and in the same way

Question 7: Do you have any ideas about ways to evaluate the implementation of the client service model?
- Hopefully allow for the implementation quickly
- Look for consistencies especially in the intake processes
- Provide or look for provision of appropriate training and resources for staff members
- Look at consistent work practices between provision areas

XI. Interview with Penny Heley
Interviewee: Penny Heley
Interview conducted on: March 26th, 2007
Position held in organization: Team Manager and Welfare Worker at Mitcham office (VAF)

Summary: Penny Heley first received her degree in sociology. She was an adult educator with the degree in New Zealand for a time. When she moved back to Australia, she started a job with an aged care facility where there were clients of differing disabilities. After receiving a diploma in counseling, Penny began work with VAF as a Day Program coordinator and from there became a Welfare worker. When the organization then began to have one manager be responsible for two offices, Penny applied and earned the title of Team Manager to act while the manager was at the second office. As a welfare worker, Penny will travel to the client's home and have a conversation outlining every available service and product available through VA as well as anything available outside the organization for extra help. After discussing with Penny the new client service model, she became aware of two problems. The first was the loss of the day programs as they were previously only a VAF concept. The second is that the staff at the Mitcham office, an ex-VAF unit, prefers the RVIB model of specialties and one service coordinator even though they have used previously the concept of everyone doing service coordination.

Question 1: What is your background with the Vision Australia organization?
- Worked for the past 5 years at the Mitcham office
- Prior to that, spent 4 years at the Box Hill office, the original placement for the Mitcham office

1. Moved from Box Hill office because was on second floor in a business building
2. Were not allowed to display information in front of building showing where they were located
3. Difficult to actually use as an office because had little space for client and staff interactions as well as front foyer areas where information is kept

- Originally worked with the Kooyong office
- Has always been with VAF organization and used their model for client service provision.

Question 2: What is your position with the organization exactly?
- Penny was originally a day program coordinator with VAF meaning she ran the day programs offered by VAF to their clients
- After obtaining her diploma in counseling, she went into the specialty of welfare.
- From there, she applied at a later date to hold the Team Manager position as well

Question 3: What exactly is the position of welfare within the organization?
- Welfare workers are responsible for the initial contact with clients at their home and the original assessment
- The worker will talk with client about all available products and services based on the topics of conversation and concerns the client has
- Welfare workers make the appropriate referrals to OTs and O&Ms when needed.
- She does counseling with the clients as well especially because she has the degree
    1. Any concerns they have about their vision loss
    2. Emotional problems stemming from loss
- Speaks with the client about any additional benefits they are entitled to
    1. Blind pension
    2. Taxi card
    3. Day Program assessment
    4. Travel pass
- Welfare worker does this with clients not choosing to attend the low-vision clinics
    1. 30min prior to program same information is given out in detail to clients participating in clinic

Question 4: What are these day programs? Are they only offered through former VAF locations?
- Originally, the day programs were designed as a socialization tool for individuals who are socially cut off due to vision loss typically
- Can usually be of any age group-clients who feel isolated because of their vision loss
- Provides a social setting to get the clients more involved in life and social environments
- Recently, has become more of a social group with less attention on performing any tasks
    1. Some times there will be a cooking session
    2. Lunches
    3. Speakers are brought in
    4. Day trips
- 2 staff members and at least 5 volunteers are always there
- VAF has always had the day programs and they have always been a large part

- RVIB did have them but cancelled them many years ago

Question 5: Do you have any concerns about the new client service model? Anything you are really excited for?
- Penny is worried about the day programs and whether they will continue or not
- To her understanding, the new model indicates that the programs will be run out of other community centers.
- VA staff will work with community center staff to ensure everything is prepared for clients who have low vision
- Not directly working with clients like in the past
- Penny would like to see the programs continue

Point of note made by Penny:
- The staff at Mitcham (former RVIB) do not like the model where everyone is a service coordinator
- Staff members want to concentrate on their specialties more and like that concept in the old RVIB model
- Example given was:
    1. A welfare worker is capable of marking a stove for a client they see while at the home. However, they are not an OT and have had none of the training in that area. They do not look for other dangers or problems associated with that stove. They don't know if that client should actually be using a stove in the first place. As a service coordinator, worried that they are not giving the full attention to clients in areas that the service coordinator is not familiar with.

XII. Interview with Mark Janes
Interviewee: Mark Janes
Interview conducted on: March 22nd, 2007
Position held in organization: Service Coordinator in Boronia office (RVIB/VAF)

Summary: Mark Janes has been acting as a service coordinator for approximately 6 months after filling a maternity leave temporary position that became a permanent position. His background is in welfare management. Previously, he had worked for VAF as both a service coordinator and welfare specialist under their business model. As the service coordinator, the main focus for Mr. Janes is to meet with new referrals to determine their goals. After establishing these, Mr. Janes would then direct them to the appropriate specialists such as the OT or O&M for the actual services and products. In terms of outcomes expected from this position, Mr. Janes says that everything is based on the goals of the client and from there the appropriate products and services are discussed. At completion, it is usually an informal review of whether or not those goals had been accomplished. Concerning the new merger and the new client service model, Mr. Janes is most worried about the key contact position and its effect on his job. The document seems to suggest that all individuals within an organization will become a key contact to clients and perform the same duties of Mr. Janes in terms of meeting to discuss main goals clients have for services and creation of plans.

Question 1: What does your position as service coordinator entail?
- Has been service coordinator for 6 months. Background is in welfare. Serves as the first point of contact for new referrals.

- Conducts interviews for the purpose of initial assessment. Determines general idea of client goals.

Question 2: Did you have a pre-merger affiliation? Which organization were you a part of and what was your position? Were there significant differences between the two systems?
- Originally with VAF, joined RVIB prior to the merger.
- VAF used a more paper-based record keeping method. RVIB has a computerized database that does the same sort of record keeping.
- VAF model relies on telephone interviews in place of the face-to-face interview employed by RVIB.
- VAF model relies primarily on its "low vision clinic" where clients come in to a given site and participate in activities. RVIB is more home-based. VAF used to be more home-based but received more funding to implement the low vision clinic.

Question 3: How would you define a positive outcome for a client in your field?
- Keeping independence and comfort. Maintain of increase the level of enjoyment in the client's life.
- Client signs a "summary of agreed actions" which is a contract between VA and the client that VA will, to the best of its ability, ensure that any goals set forth by said contract are achieved.
- For a service coordinator, outcomes are quite diverse, anything from getting around better to improving social interaction.

Question 4: When you interact with clients, is it always outcomes based?
- Yes, service coordinator interaction with clients is always outcomes based, although it focuses more on the client's goals, rather than the specific outcome they experience.
- Some outcomes are clearer cut than others. For example, being able to read the paper better has a clearer cut success indicator than does improving social interaction.

Question 5: Do clients seem to prefer informal discussions about goals or outcomes?
- Clients seem to prefer a face-to-face interview, however, no real insight. It gives service coordinators a better, more rounded view of the client and their situation.
- Face-to-face interviews also build client-service provider rapport.
- Telephone interviews are quicker and easier for the purpose of taking a quick snap shot of the client situation.
- The real issue seems to be what works best in terms of service provision.

Question 6: Have you had any experience with outcomes assessment in the past, either with VA or any other organization? Do you have any suggestions or things you would like to see implemented in terms of outcomes assessment?
- No specific suggestions about what should or could be implemented. All pre-service provision work is based on goals and outcomes.
- Some outcomes are more quantifiable than others. Things like counseling are more abstract. Outcomes assessment is based on follow up. There is no follow up in the current RVIB model being used in Boronia. Outcomes are assessed at termination of service provision, usually 6 months or earlier from the initial creation of the summary of agreed actions. Sometimes earlier depending on the service being provided. It takes longer to complete some services than others. Example: learning to read braille may happen faster than learning to cope with one's visual impairment. So service

coordinator's 6 month follow up may come before 6 months.
- VAF system had a "telecontact" where volunteers would call clients at some point after the service provision had ended to see if there was anything else they wanted or needed.

Question 7: Are you familiar with the new service model document? Do you have any concerns or suggestions about its implementation?
- Concerns would be the action of bringing two groups together that have been used to doing things differently for so long. Not concerned with staff conflict but more data base and record keeping conflict. The two systems are different, which makes compiling all that information difficult. Also, when do you decide which one to use exclusively, and how do you decide that?
- Where does the concept of the key contact fit in? Shares the workload concerns of the other service provision personnel. What does Marks job become if everyone is a service coordinator? Does he go back to using his background in welfare?
- It is still unclear what is going to happen with the implementation of the new model. There is a need to clarify what is going to happen on a practical level.

XIII. Interview with Lauren Johnson
Interviewee: Lauren Johnson
Interview conducted on: April 13, 2007
Position in organization: OT in Newcastle (RBS)

Summary: Lauren has worked with RBS for three years as an OT. She works with people of all ages, and her outcomes are generally goal based. She had much to say on the switch to an outcomes-based assessment of clients as well as client intake issues. Lastly, Lauren referenced the project team to another woman in her office that could serve as a useful source for outcomes assessment.

Question 1: Could you please provide some background information on your training and experience with the organization?
- 3 years with RBS/VA
- First job out of college

Question 2: How would you define successful client outcomes?
- With children its more like little goals (like tying shoes), goals are developed with older children (helps to motivate them) and parents help with younger children
- Adults identify their own goals

Question 3: Do you personally discuss outcomes with the clients? Do you know of any outcomes assessment techniques used in the past?
- She prefers a client-directed outcomes assessment, perhaps where they sign a contact about meeting expected outcomes
- She would also like more outcomes measurements
- Newcastle office staff look for different types of measures
- When the VFQ-48 was mentioned, Lauren agreed with its use
- Canadian Occupational Performance Measure occasionally used in Newcastle

Question 4: To what extent do you understand the new service model of VA and what are some suggestions you have about its implementation?

- Still working under RBS model as far as she knew, no real knowledge of VA model
- When asked about intake, it was suggested that 1300 number be improved. Clients looking to call Newcastle to ask a question have to call the 1300 number and are referred to about 3 other places before their question is answered
- Perhaps have extensions to individual service providers from the 1300 number that a live person could refer them to
- When asked about intake staff, it was suggested that intake staff have some counseling background, as the first call to VA is an emotional experience for some.
- It is essential that safety is taken to account during pre-assessment (when asked about IVI's safety content, Lauren agreed with its purpose)
- Electronic files are used but hard copy backups are immediately printed
- Service coordination depends on intake, case sensitive
- Service coordinators should have holistic background (OT, psychologist, etc.)
- Coordination duties can be burdensome on some people

Also suggested that the project team contact Jenny Lambert, also in the Newcastle office.

XIV. Interview with Garda Kroes
Interviewee: Garda Kroes
Interview conducted on: April 11, 2007
Position in organization: Manager in Heidelberg (RVIB)

Summary: Garda has been employed by Vision Australia and RVIB for 11 years and worked as an OT. Garda had some fantastic ideas concerning client outcomes evaluation, the new service model, and the need to delicately handle the outcomes assessments of the elderly clients of Vision Australia.

Question 1: Could you please provide some background information on your training and experience with the organization?

- 11 years with organization
- Originally an OT in St. Kilda, became team leader
- Founded Oakleigh service center, and brought St. Kilda staff with her

Question 2: How would you define successful client outcomes?

- Clients gain a sense of independence and are satisfied with their services

Question 3: Do you personally discuss outcomes with the clients? Is it an informal setting?

- There is an initial intake interview conducted by the service coordinator
- They become the key contact refer clients to services
- They meet at the end and the service coordinator closes the file and discloses outcomes information when prompted
- No service personnel close files to prevent biases when collecting outcomes data

Question 4: Which means of outcomes assessment is preferred by the clients?

- Elderly clients are phoned by many agencies, and they forget which is which

- Service coordinator phoning the clients about outcomes is best, as they have built a rapport with the clients and that familiarity builds security in the clients and allows more honest and accurate outcomes information
- Task specific outcomes measurements made be best, because especially with the elderly causation would come into question on larger goals

Question 5: Do you know of any outcomes techniques used in the past?
- Service coordinator brings any client complains to Garda, who meets regularly with the service personnel. The close monitoring was said to pay off.
- They used to have a client survey conducted over the phone by a third-party agency, but trust was an issue and this system was abolished during the amalgamation into VA
- The sample selection of those surveys was weak, too random

Question 6: Do you have any suggestions for the implementation of the new client service model (intake, outcomes, etc.)?
- Intake: two options (service coordinator or multidisciplinary [OT/service coordinator, for example])
- RVIB originally used the latter approach
- Garda advocates the separation of service coordination
- Multidisciplinary service personnel tend to put client support secondary
- Follow up on clients and outcomes tends to lag, as these personnel have new files to examine
- Service personnel generally know of services in other communities they can refer their clients to, which is hindered if they have another discipline to worry about
- Service model: what is developed not how.

XV.   Interview with Maree Littlepage
Interviewee: Maree Littlepage
Interview conducted on: March 28th, 2007
Position in the organization: Regional Manager of Boronia/Mitcham offices (RVIB)

Summary: Maree Littlepage has her background in classroom teaching. She was promoted to principal and manager of education in 1998. From there she took a position as the regional manager for the then RVIB office in Boronia and now holds the position in the VA organization. Maree is on a design team that has not yet met but will look into the very broad and encompassing issues in the organization like client eligibility and resource allocation. She also explained that the action teams, comprised of only service provision staff have already met and have the main goals of working with the actual services, their provision, and benefits to the client. Maree would like to see a starting evaluation in terms of outcomes assessment so that the service staff and the client have a firm concept of the actual starting point. She would also like something more concrete to be given after the completion of service so that the impact can be seen. A major point Maree stressed was that most clients say that the services or products greatly impacted their lives but wants to be able to more quantifiably determine the amount of impact and where improvements can be made. She also noted that though mail surveys are often difficult for the clients to fill out themselves and can lead to bias, phone and in person administrations would be very difficult for the VA organization.

Question 1: What is your background and experience both within the VA organization as well as before?
- 1984—Taught in the classroom setting
- 1998—Manager and Principal of the school as well as the educational services of Burwood
- Spent past 3 years at VA under the RVIB method
- 1998 the services of RVIB went from centralized (all individuals of one specialty in one office) to regionalized (where typically one of each specialty at least in the offices)

Question 2: What is the role of the working group and who makes up the group? How often does it meet and what are the main goals?
- Managers, like Maree, make up the team
- The working group is appropriately termed the Design Team
- Action teams are the other new implementation
    1. Made up of service providers
    2. Deal with the actual services being provided to clients
    3. The particular service models being used
    4. Currently have already had training
- Design Team looks at allocated resources
    1. Look at the overlying issues
    2. Eligibility of clients
    3. Possibility of self-help groups
    4. OATs ideas
    5. Service evaluation and continuous improvement concepts
    6. Further ideas about design teams sent in emails from Maree
- CSM8 is one main team- 8 members
- Client Service Senior Management Group
    1. Aleks Zdravkovic
    2. Margaret Noonan
    3. Janie Power
    4. Ian Moore—Senior Business manager who oversees budgets and the like
    5. Chris Edwards—oversees the government funding aspect of the organization
    6. Graeme Craig—responsible for client services and the development of the model. Also oversees the client management system
    7. Christine Harding-Reports to the CEO
- CEO of VA works directly with the Executive—several senior managers sit on that council

Question 3: As you are on a Design team, have they met yet? Are any goals outlined?
- Haven't had any meetings as of yet
- No dates have been decided on
- Wanted to start with the action teams first
- The action teams had training but the design team has not yet
- No development of purpose yet

Question 4: Have you had or have you heard of others having any miscommunications with the service model document or implementation?
- The action teams were confusing to staff as far as purpose and who was chosen to be leaders

- The original document received was a very lengthy document
- Following receipt of the document were several attached appendices that were later thought to be the actual model
- Most likely stems from individuals not reading the document fully or having misunderstandings
- Probably benefit everyone with understanding if the original document is read again

Question 5: These particular misunderstandings, has anything been put into place to fix uneasiness had by the staff?
- The action teams and design groups are meant to clarify the model
- The teams need to get a better handle on the document and the meanings for progress forward

Question 6: Now that the team leader position is going to be thrown out, do you think that is beneficial to the organization or do you foresee problems?
- The only problem will be when manager is out of the office for sick leave or vacation etc
- At that point need someone to go to with issues concerning clients or organization and the like
- RVIB used to have senior officers in each discipline that was relied on in these situations
- Service Coordinators will be helpful as well because they often deal with clients
- Good to not have the position because it avoids creating a hierarchy in the organization and in each office

Question 7: We know that Mitcham and Boronia are merging into one center. Are other offices doing the same?
- Yes, many are being combined
- Example, St. Kilda will soon be under an old VAF manager

Question 8: Do you have any suggestions for us in terms of outcomes assessments or implementation of the framework?
- Need to have a starting point in every discipline to help later understand how far the client has come
- Need something to use after service for a decided, measurable outcome
- Need to know what a client can and can't do as well as why they can't do things and the overall impact of the organization to the client
- Important for VA to determine overall impact because that is why they are in this particular field
- Need to be able to measure accurately the impact—some clients are pleased while others ecstatic
- Funding bodies still want to see outcomes based on independence—can they get to a train, shop, cook, etc
- New information is available through Maree concerning the new disability measurements concerning outcomes in Victoria
- Important to be able to measure outcomes necessary for funding but also important to have an internal concept of impact and continuous improvement

Question 9: During our interviews with clients, are their any specific things or questions you would like us to find out about?
- Determine what a client is willing to work with. An assessment of 50 questions that are structured or 5 those are general.
- Most of the clients in the model will at some point have dealt with a survey—what are their thoughts?
- Phone and in person administration of outcomes assessments would be near impossible for VA because of the time required and the number of clients
- Maree liked the idea of incorporating assessment into key contact or service coordinator follow up phone call

Points of interest offered by Maree:
- Contact the Burwood Residential Training at a school
- Run by Gary Stinchcum
- Meets next week
- Has younger clients around 16-18 years
- Most have received visiting teacher services but some may have received others through the organization
- Pertaining to the interview strategy—the Employment advisor would be feasible replacement for interviews by contacting Robin McKenzie for ex-RVIB agencies because still centralized. Other agencies go through service centers
- In service model, volunteers are recommended as possibility for outcomes assessments and other help but can VA really do this? Is it feasible? Will they be experiences enough?
- With clients—how do we create an outcomes assessment that they will feel comfortable answering the questions? Need honest answers but will they always give them?

XVI.   Interview with Sandie Mackevicius
Interviewee: Sandie Mackevicius
Interview conducted on: March 20, 2007
Position held in organization: Early Childhood Educator

Summary: Sandie is an Early Childhood Educator who only works with children from the age of 0 to 6 years. At this level, goals are discussed by Sandy with the family to determine what they hope to achieve with the help of Vision Australia. The goals in this specialty are not as rigid as those used by the OTs and the O&Ms due to the fact that children grow quickly and needs and abilities change. Mobility, for instance, for a child would quickly progress from sitting up to running in a matter of only a few years. To assess the progress, Sandie and other Early Childhood Educators use face to face interaction with the client's families to continually assess whether or not they believe goals have been achieved, if new goals have developed, or if a successful outcome has been reached. Sandie noted that the current assessment tool in place at VA is an evaluation at the end of 6 months time. Her concerns arose from the fact that not every client of VA will be with the organization for 6 months while others are with the organization for many years and wondered if a more feasible outcomes evaluation could be developed to incorporate the change in length of service as well as the fluidity of child goals.

Question 1: What does being an Early Childhood Educator entail fully?

- Works with children and families of children having suspected or diagnosed vision impairment.
- She works with children from birth-6 yrs of age.

Question 2: What organization did you work for before the merger? Which policies do you use in your daily work?
- Always been with RVIB
- Still uses the RVIB model and there has been no restructuring yet in her area.

Question 3: To what extent to you interact with clients or in this case the families as well? To what extent do you discuss outcomes assessments? Perform them?
- She talks with the families about their goals for the child as well as the family as a whole
- Discuss goals in a stepwise fashion at times like orthoptic assessments, physical therapy sessions to assist in strength, or even goals like achieve kindergarten or able to go out in public as a family.
- Recent example was with young boy having cataracts already removed since birth:
    1. Acts as if completely blind baby
    2. First goals initially to allow for movement
    3. Future goals to come as child ages and detriment determined
- After a period of time, do family review to determine what goals have been met or are unmet, any new directions want to take, etc.

Question 4: Do you perform any specific outcomes assessments right now even though you interact mainly with young children?
- Original concept of goal setting
- After a period of time do family reviews
- Family service and support plans to follow but usually only if the individual stays with the organization.

Question 5: What specific programs do you use on the computer? Any evaluations within the structure?
- When you go to close a case, there are a series of tabs you have to go through
- One is the actual reason for closing a case-helps determine if there were any problems with delivery of products or dealings with individuals at the organization.
- Question also has to be answered as to whether outcomes were satisfactory to client
- In general, discussion occurs between organizational member and the family and from there inferences are made as to satisfaction. Not a question directly asked.

Question 6: What would you describe as a possible outcome for your part of the field?
- Very dependent on age and level of disability
- For a baby-may just be achieving traditional milestones like crawling and walking
- The goals tend to be very fluid as they come about in response to something else and are harder to judge as specifics.
- Tend to have families make broad goals that are understanding to all like mobility
- Important to also address family goals like sleeping at night, going to daycare, going shopping and being safe and happy

Question 7: Are you familiar with the new client service model? What do you think of it in general or as it pertains to your field?
- Worried that the Early Childhood aspect is being overlooked
- New service model has there being a shift from education to life skills in the early childhood field
- Already in place in NSW but RVIB has never conducted assessments in that manner
- Transition might be difficult for some people that have always been with RVIB

Question 8: Do you have any suggestions for improving the method of assessing outcomes?
- No real suggestions at this point-going to bring info to us as soon as she thinks about it
- Is important to note that assessments are conducted every 6 months theoretically
- Fine for clients and children that are always going to be in the system and need help
- Falls short when individual clients are only seen for a short period of time.

Points of note offered by Sandie:
- Contact if possible Early Childhood Intervention Australia
    1. Give help solely to children coping with low vision or blindness and their families
    2. Sandie is a member
    3. Currently attempting to look into outcomes specifically qualitative in other organizations—may have tools to use and look into

XVII. Interview with Caroline Maplesden
Interviewee: Caroline Maplesden
Interview conducted on: April 11, 2007
Position in organization: O&M in Geelong (VAF)

Summary: Caroline has worked as an O&M for 27 years and has worked under the VAF model in Geelong for 20 years. She is a member of an action team under Luke Price. She had some fantastic ideas concerning service coordination, as she currently serves that capacity. As Caroline was unfamiliar with the new service model document, the interview questions took shape quite differently.

Question 1: Could you please provide some background information on your training and experience with the organization?
- O&M
- 27 years working with Vision Australia/predecessors
- 20 years in Geelong

Question 2: How would you, as an O&M instructor, define successful client outcomes?
- Referrals are established from doctors or service coordinators and from there home visits are established
- Clients discuss what they would like to do, generally on a basic level, and Caroline helps them to accomplish these

Question 3: Do you personally discuss outcomes with the clients? Is it an informal setting? What do they prefer?
- Service pathway of VAF generally not used

- Outcomes discussion verbal, since the program can change
- Outcomes assessment needs to be flexible, it looks bad for the service provider when written outcomes aren't achieved but that is only because clients have developed new ones.
- Verbal assessment better because of the rapport developed with clients

Question 4: Can you suggest strategies for client outcomes assessment that would be easily integrated into the new system? Any modes used in the past?
- Luke Price is the leader of her action team, only discussed the model briefly (has not read it)
- Outcomes assessments should be in the words of the client, make it as client based as possible.
- The service pathway could be useful to ensure that every discipline is accounted for.

Question 5: Do you have any concerns with the new service model? Could you provide suggestions on client intake and service coordination?
- Currently she sees no problem with either in Geelong
- Workload varies from office to office, but in Geelong welfare specialists take most of the service coordination duties, allowing O&M's and OT's to free up.
- For service coordination duties to be effective, the team needs to be flexible and have good teamwork.
- Checklists ought to be used to ensure consistency, and some people can naturally elicit information from clients and others cannot. These people also have to have good relationships with everyone in the office to ensure smooth referrals
- Electronic intake appears to be smoother, but hard backup copies would be good. Internet crashes there a lot, and it would render the office useless.

XVIII. Interview with Plaxy McCulloch
Interviewee: Plaxy McCulloch
Interview conducted on: March 19, 2007
Position in organization: Orientation and Mobility coordinator at Boronia office (RVIB)

Summary: Plaxy is an orientation and mobility instructor working in Boronia. Plaxy worked with the VAF organization then moved to the RVIB business unit at Boronia. Goals are a big part of Plaxy's work, yet the goals are very much defined by the client. As a former service coordinator, Plaxy fears for the implementation of key contacts and the implications on her work.

Question 1: What exactly does orientation and mobility entail?
- O&M is about getting from A to B with a vision impairment
- Services are coordinated with other specialists
- Service approach depends on the needs and mentality of the client
- Training and service provided depend on age and goals set

Question 2: Were you with RVIB prior to the Vision Australia merger? If not, where?
- Originally worked with VAF but then moved over to RVIB (current model used in her work)

Question 3: How would you define client outcomes? Do you feel as though VA's services currently achieve these outcomes?
- Orientation and mobility related: client outcomes are directly parallel with a client achieving a goal and increasing independence, confidence, and safety.
- O&M providers can assess the accomplishment of these goals objectively
- By setting goals for themselves, clients are determining their own outcomes
- Goal-structured approach: helps client focus on short term goals so that upon completion they get a feeling of success.
- When the client is content with the progress they've made towards a goal, they can stop striving for it (it is, after all, their goal)

Question 4: To what extent to you interact with clients about outcomes? Does it appear as though clients prefer informal, discussion based outcomes assessments?
- Once the clients complete all the goals they set out for themselves and no longer need her, Plaxy leaves the clients to do their business
- The clients are welcomed to contact Plaxy if they desire assistance in completing new goals, but no contact is initiated until then
- Clients do prefer discussion based outcomes assessments however written surveys are particularly useful for when a client cannot visualize what their goals are
- RVIB: no paper forms for outcomes; as you close the file of a client on the computer system, it asks if the client was satisfied with the outcomes, if they met their goals, etc.
- VAF (when Plaxy worked with them): Paper forms used to describe in writing what the goals of the clients were and required a logged start and completion date for the goals
- The two above systems are generally similar, VAF was just more cut and dry
- Plaxy takes notes if client has outcomes desires that are interdisciplinary, however she only discusses O&M related goals with the clients

Question 5: How familiar are you with Vision Australia's client outcomes assessment methods?
- While with VAF, Plaxy was informed that client outcomes audits would occur that the service provision personnel would be unaware of but there has been little or no mention of the new Vision Australia plan for client outcomes

Question 6: How familiar are you with the client service model document and its goals?
- Not familiar with service model document as a whole (but has a copy)
- Fairly familiar with O&M section of the service model, and has a few complaints:
- One complaint is that the key contacts, although requested by the clients, were not the best idea.
    1. At VAF (both then and now), everyone was a service coordinator and no one was specific service provision personnel (although they all had some expertise)
    2. It would be great if they had professional service coordinators that referred to people like Plaxy, however Plaxy hated provisioning service and thus did a poor job of it which is not fair to the clients.
- Another disagreement with the service model was the use of volunteers in O&M
    1. Training volunteers under O&M personnel is only useful if there is a shortage in O&M staff

2. Initially, Plaxy thought that she needed volunteers that she could train but realized that ultimately it was just because there was an O&M staff shortage
3. Volunteers, if relied on to provide service, may take it upon themselves to assume other duties typically assigned to professionals

Question 7: Do you have any comments or suggestions pertaining to client outcome, the service model, or the implementation of either?
- Data ought to be collected by people not providing the service (O&M people generally develop friendships with clients and that could skew results)

XIX. Interview with Barbara McKenzie
Interviewee: Barbara McKenzie
Interview conducted on: March 28th, 2007
Position in the organization: Team Manager of Heidelberg (RVIB)

Summary: Ms. Barbara McKenzie began in Early Childhood Intervention but now holds the Team Manager position in Heidelberg.

Question 1: What is your background with the pre-merger organizations and in general?
- Has spent 12 years with the VA organization
- Came originally for child services in Early Childhood Intervention
- The center became regionalized and she took on the management position
- Currently oversees the staff and that the clients are all receiving services they need
- Has a service coordination case load as well

Question 2: To you, what is a successful outcome?
- Client is able to express satisfaction/dissatisfaction
- The client can work through vision loss with strategies and skills and equipment so they are able to stay as independent as possible
- For children, she wants them to develop into society as normally as possible so they can stay independent students
- She wants all information available to be given to the client so they are as informed as possible
- Wants the client to still be able to contact the organization comfortably

Question 3: To your knowledge, has there ever been any outcomes assessment in the past?
- Has been a difficult task in the past
- Currently have post service follow up and pre-service goals
- Service coordinator is the staff member that calls after service to see if the client's goals have been met
- Very subjective and not done with effective documentation
- Client Management System seems subjective as well
- Nothing is recorded the same by any staff members and no qualitative information is given in any detail

Question 4: Do you have any suggestions on how to attain this information? Any technique you think would work?
- Individual service plans worked with some groups of clients

       1. Created a contract between service provider and client about goals to attain
       2. Kept the goal in sight for both parties

- Early Childhood is difficult to qualify into outcomes
- Traditionally deals with the child being able to function in the family and outside of it
- Accountability becomes blurred when goals are not easily seen and understood
- Documentation is something very important
- Been lacking in the past and very inconsistent
- Also, possibility that negative feedback will be discussed with clients if prompted

Question 5: Do you have any concerns about the new client service model?
- The amount of time it has taken to actually merge but with no real results or changes has worried staff
- Not much contact from former VAF offices
- Difficult to see the changes that are coming and to put the two very different models together
- Staff needs to be able to work through the new changes since they are all comfortable in the old methods used
- Concerned about locations and uncertainty about where they are going to have to move
- Getting services to other regions changes the occupational teams
- No more 2-3 night service calls to the country
- Some discomfort about the new size of the organization
- Worried it is going to be stretched out too far to maintain quality of services
- How will the old RVIB discipline teams be changed
- Will there be any senior members

XX.   Interview with Ian Moore
Interviewee: Ian Moore
Interview conducted on: April 5th, 2007
Position held in organization: Senior Manager: Service Operations

Summary: Ian Moore is a Senior Manager of Service Operations making him responsible for the overall finances and monitoring of the development process. He is originally from the VAF and he considers client outcomes to be part of three different levels, namely service access, practical/functional client activities, and finally, client satisfaction. He also believes that client outcomes must be centered around the client experience, and that clients must understand their own limitations. He also provided some information on Vision Australia's use of the SERVQUAL instrument. He is confident that the success of the new service model is indicated by more clients being served more efficiently.

Question 1: What is your role as service operations manager?
- Responsible for overall finances and monitoring of the development process. Also in charge of the client services business plan and the related client services plan.
- Handles individual staff evaluations and training. Believes very strongly that the training departments from the old organizations need to be brought together.
- Also handles general administrative tasks and relationships with other departments headed by the other senior managers.

Question 2: What is your pre-merger affiliation?
- VAF

Question 3: What is your idea of an important level of client outcome?
- Client outcomes are very client specific. It is important to understand the client experience. The first measure is service access, to determine if the client has actually been made aware of all the choices they have in service provision.
- The next level is the practical/functional things the client can do as a result of the service. This is where the outcomes assessments come in.
- The final level is client satisfaction. Some clients come into service provision with unreasonable expectations, but that doesn't mean the outcome is unsuccessful.
- The important thing is to be able to capture what the client wants to be able to do before the service and compare it to how they feel after the service has been provided.

Question 4: Do you have any suggestions about how client outcomes assessment could be done?
- The process must center around what clients want to do. They must understand their own limitations.
- The organization is currently measuring outputs that do not indicate outcomes.
- The critical thing is identifying the results in terms of the client. This results need to be in the form of action statements- "I can prepare my meals."

Question 5: Are you aware of any forms of outcomes assessments used by Vision Australia in the past?
- There have been a few different attempts made. The first to come to mind was SERVQUAL, which he considered to be a very good assessment tool but there simply were not enough resources allocated to its use.
- Department of Human Services has a set of 9 disability service standards for Victoria. There was an annual self assessment of the organization to see if all 9 standards were met, and also assessment of quality of improvement. This particular assessment was very complex and cumbersome and so it is not done any longer.
- There is never a solution right off the shelf.
- SERVQUAL was a gap analysis tool that would match the expectations of the client with the expectations of the service provider. It also focused on outcomes and the goals of the client.
- Thinks the IVI is a good assessment tool but is concerned that it does not assess the whole client in terms of things that are not related to vision loss.

Question 6: What indicates the successful implementation of the new client service model, and do you have any concerns about the new model yourself?
- No concerns about the service model because he was part of the team that wrote it.
- Indicators that the model has been implemented successfully are that Vision Australia is serving more clients, service delivery is more efficient and and the process is standardized. There needs to be a quantitative cost of service unit, and the question of whether or not there is equal service access needs to be addressed.
- It all comes back to outcomes assessment and the result of the client experience.

XXI. Interview with Tim Nolan

Interviewee: Tim Nolan
Interview conducted on: March 30, 2007
Position in organization: Independent living services and Orthoptist in Canberra office (RBS)

Summary: Tim Nolan is a graduate of Sydney University class of 2002 who is now an independent living services aid and an orthoptist in the Canberra office of VA. He believes that clients would participate in a structured outcomes assessment if led to greater results. He also mentioned that currently, his office sends out a questionnaire prior to the first meeting between client and specialist as a catalyst to the conversation concerning needs. From there, after discussion, goals are decided upon and the correct services and products looked into. The biggest concern Tim has with the new model is that the specialist of orthoptist and optometrist are very different between the old pre-merger organizations but are now holding the same capacity in the VA organization. He wants to know how the description of the role will change and be implemented appropriately so that all services are still available and everyone is standardized.

Question 1: What is your background with the organization and what is it you do on a daily basis?
- Sydney University graduate of 2002
- Some experience with laser surgery
- Started with VA last year
- Does low vision clinics
- Talks to clients and assesses their level of vision loss
- Has a functional vision assessment clinic for children
- Does an occasional home visit

Question 2: What is your pre-merger affiliation?
- Affiliated with RBS

Question 3: How would you define a successful outcome in your specialty?
- He wants the client to be emotionally happier after the assessment and have a better understanding of their vision loss
- He believes that clients would be willing to participate in a standardized structured survey that could ask these questions

Question 4: Do you speak with clients about outcomes on a daily basis? If so how? If it is informal do they tend to prefer this method?
- Outcomes assessments are done in an informal manner
- There is a questionnaire that goes to the client before being seen so that it is ready when he arrives and they can discuss overall needs
- Questionnaire is sent to clients when they make the actual first appointment
- Usually in large print though some clients get relatives to help fill them out
- There is a specific section in which the relative or friend fills out information so as to make sure that it is known that the client did not fill it out for themselves
- Not fool proof and can be improved upon
- Occasionally done over the phone and usually includes 10 questions aimed to identify other necessary services for the client
- Usually is the first contact for individuals unless they mark that they require low vision services and actually need adaptive etc

- Also conducts informal goals assessments and settings after seeing the questionnaire
- Less formal than a traditional clinical setting

Question 5: Are you able to suggest strategies for client outcomes assessment that would be easily integrated into the system?
- Currently, case files are audited periodically by the organization to check for quality
- Done internally and usually matched back to original questionnaire
- Unaware if at this time client is contacted but is a possible addition

Question 6: Do you know of any specific outcomes assessments done by VA in the past?
- Performance reviews are done to assess whether specialties are performing their job to the best of their capabilities
- Scale is from 1-5
- 3 indicates acceptable
- Below 3 is seen as unacceptable
- This is used to then show to staff and determine pay bracket

Question 7: Do you have any concerns with the new client service model? What do you think would indicate it has been successfully implemented?
- Main concern he has is how people are booked into service.
- Questions are vague and could lead clients to the wrong service choices
- Also very large difference between orthoptists and optometrists between NSW and Victoria.
- How will roles change between the original uses of the specialists to the new model?

XXII. Interview with Margaret Noonan
Interviewee: Margaret Noonan
Interview conducted on: March 23rd, 2007
Position in organization: Senior manager of Region 3 in Enfield (No pre-merger affiliation)

Summary: Ms. Noonan has only been with the organization of VA for 4 months and has no pre-merger affiliation. Her current job is to help staff understand the new service model. She is the Senior manager of region 3, so she over sees the way all offices in region 3 are run, and ensures that clients continue to receive the service provision they need. She is also responsible for setting up multi-disciplinary teams from the old service teams which had not been multi-disciplinary. Ms. Noonan is also trying to work out how to integrate a much more widespread use of volunteers as per the new service model.

Question 1: What was your role in the design of the new service model?
- She has no real role in the design of the new service model. Her role is to make the model simpler to implement and easier for staff to get used to.

Question 2: How would you define successful outcomes? Does the current service model lend itself to outcomes assessment? What about the new one?
- The current model misses the "nitty gritty" of the things VA has been contracted to do by the government. It does not make staff aware of what they are really required to do.
- The new model adds new services that do not have government contracts and so need to be negotiated into government contracts so that they can receive funding. This

adds to the amount of things staff are required to do.
- Part of being able to get these government contracts is being able to show that the organization is having successful outcomes. These contracts must also agree with the clients needs.

Question 3: Are you familiar with the Regional Client Committees? What is their role and how is it different from the client representative council?
- There are three levels to the Client Representative Council, the first are the low vision groups that meet at various service centers across the organization to discuss vision loss and their current condition. Each low vision group chooses a delegate to be part of the Regional Client Committee. This committee discusses problems or concerns voiced by members of their individual low vision group. One member from this committee is chosen to be the Client Representative Council that meets with board members and executives to discuss generalized problems or concerns with service provision or anything pertaining to the organizations relationship with clients.
- The idea behind the different levels is that the problems identified by the Client Representative Council are generalized across the organization so that big problems can be solved quickly, rather than sifting through specific client complaints.

Question 4: Do you have, or have you heard of, any concerns about the new client service model and how it will be implemented?
- Nothing significant, she has only been around for 4 months. Problems are identified through the implementation team which she is a part of.

Question 5: Can you explain the role of the working groups? What have their findings been so far?
- She is unfamiliar with the term "working group". Similar to my explanation of working groups are the action teams, of which there are about 50. Their job is to look into the detail of how the new model is or is going to be implemented out in the field. Members of these teams are service provision personnel. The design team is a group of senior managers whose job it is to modify the design of the new client service model to make it more implementable.

XXIII. Interview with Ruth O'Connell
Interviewee: Ruth O'Connell
Interview conducted on: April 10th, 2007
Position held in organization: Manager of Bendigo Office

Summary: Ruth has been with Vision Australia for going on 18 years. She started as a welfare specialist and has now moved to a management roll. She ensures that staff are doing things correctly and efficiently and also deals with funding and budget making. She was originally with the VAF in a welfare specialist role. She thinks that clients reaching their goals and understanding their vision loss is very important to client outcomes assessment. She also looks forward to joining the organization into one cohesive group so that information about clients and services can be shared and recorded properly. She believes this will lend itself to client outcomes assessment. She mentions random client assessments done by the marketing department to gage client satisfaction, and she is concerned about the role or peers in the new service model regarding their training. Her idea of successful model implementation focuses on the idea that the model will never be perfectly implemented because the job to be done changes rapidly and frequently.

Question 1: What is your background and what do you do on a daily basis?
- Has worked with Vision Australia for approximately 18 years. The first 8 years were spent in welfare and the last 10 years were spent in management.
- Her everyday activities include managing all the staff an volunteers and makes sure they all do the job they are supposed to do. She also deals with funding and budget making.

Question 2: What is your pre-merger affiliation?
- VAF

Question 3: How would you define a successful client outcome?
- When a client's needs have been met and they have achieved their goal. They understand their vision loss.
- Clients have the ability to do the things they want to do with their lives.

Question 4: When you deal with clients, is it outcomes based?
- She visits day centers to get feedback from clients about their services and to determine whether or not they have achieved their goals.
- Sometimes she does a client intake or two when staff are over worked, so she deals with the goals.

Question 5: Can you suggest strategies for client outcomes assessment that would be easily integrable into what is already done?
- She is really looking forward to merging the staff from the RVIB and VAF because she wants to be able to use the widespread nature of the organization for information sharing.
- The ability to share information will allow client outcomes assessments to be recorded and shared effectively.

Question 6: Do you know about any specific outcomes assessment tools or methods used by Vision Australia or any of the pre-merger organizations in the past?
- The marketing department at Enfield randomly selects clients to call and talk about their satisfaction with the services they have received.
- The questions are not really outcomes based however. They are more centered around client satisfaction and what the client might need in terms of further service.

Question 7: Do you have any concerns about the new service model in terms of what is proposed to be implemented? What do you think indicates a successful implementation of the new service model?
- Concerned about the roll of volunteers and peers. There was something about the wording in the new model document that indicated the peers may have responsibilities like teaching clients to use adaptive technology. Peers are not necessarily trained to actually instruct patients on how to use adaptive technology and they may not consider the difference in type of vision loss between clients.
- It will take a long time to actually determine how well the implementation has gone. There will always need to be review and updating because the nature of the organization is very dynamic. There always needs to be research into new and better ways to do things.

XXIV. Interview with Madeleine O'Reilly
Interviewee: Madeline O'Reilly
Interview conducted on: March 27, 2007
Position in the organization: Therapist (Psychologist) at Boronia office (RVIB)

Summary: Madeline is a therapist in Vision Australia working at the Boronia center. She graduated from her university 18 months ago and has worked in the same capacity ever since. Madeline will travel to a client's home and conduct an assessment as well as determine goals based around emotional needs of the client. Madeline will see clients at any age group and will also talk with families, teachers, siblings, and anyone else having an impact on the client's life. In her specialty, outcomes and goals are made with the client and tend to be very broad concepts like increased motivation or a better outlook. They are very hard to assess in terms of concrete examples of attainment and she does wonder if a rubric of sorts can be made. The only worries she has concerns the size of the counseling specialty and the level of training each member will have since therapy is a broad term that can be accomplished as a psychologist, having a counseling diploma, or in the welfare department.

Question 1: What is your background as a therapist and with Vision Australia?
- Went to university and earned degree as psychologist
- VA is the first job since graduation
- 18 months since graduation, all of which have been spent with Vision Australia
- Trained as a psychologist
  1. Will meet with any aged client from young children to the elderly
  2. Will meet with families either with the client or separately
  3. Will meet with siblings and teachers
  4. Does any meeting that is beneficial to the therapy

Question 2: Even though you just graduated, have you worked under any pre-merger organization model or only RVIB?
- Hired as a VA personnel
- Only worked under RVIB old model so far

Question 3: As your specialty is more emotional in setting, do you have ways to assess overall outcomes? What would be a positive outcome?
- Very dependent on the client met with whether goals have been established
- Some of the clients have goals in mind that tend to be general—ex improved mood or able to have further interactions in daily life
- Once these goals have been established Madeline will discuss with client what markers to use to determine when goals are met—need something concrete attached to the emotional goal
- Very hard to measure
- Goals tend to change as the client becomes more involved or active
- Currently-no standard option for outcomes measurement
- When she went to school there was a measurement tool in place with that organization
  1. After completion of service, a written evaluation was sent out to client from organization-not service provider
  2. Aimed at both positive and negative feedback
  3. Completely anonymous

4. The organization received the feedback directly-service provider never sees actual documents
- Madeline checks with client at each meeting to make sure everything is going in a positive manner-comfortable, attaining goals, etc
- Worried that the positive feedback may sometimes be clients to nervous to give true depiction—skewed results

Question 4: In your assessments and meetings, do you ever have a rubric of sorts to follow or is it always informal?
- Most of the time informal formats are best
- Changes if the client is difficult to start conversation with or read
- In a difficult setting, will often times write out specific points to evaluate so as to determine a starting point
- Also more formalized writing out of goals and concerns for finalized reports or more formal needs
- All above is done by Madeline's choosing
- No rubric for all therapists to follow

Question 5: Are you aware or have you heard of any past attempts at outcomes assessments by Vision Australia?
- Post assessment phone calls are made
- Service coordinator will also call to remain in contact with client
- No other concepts are known—definitely no written forms

Question 6: If you have reviewed the Client Service Model document, are you excited for any of it? Do you have any concerns?
- Based on the document it seems that the counseling department is going to grow
- Currently a total of 3 counselors for Victoria
- In the document refers to having one full time counselor at each center
- Unclear of the training these individuals are going to have
  1. Psychologist, counseling diploma, welfare workers, etc are all fall under therapist
  2. Will all services still be offered?
  3. Who gets what services if the qualifications are that diverse
- Also currently no senior worker because the division is so small
- As it grows, will need to have a senior worker like the other specialties to have adequate supervision

Question 7: Are you familiar with the key contact idea and do you have any problems with it?
- Not worried about the key contact idea
- Can't be applied to a counseling setting because its on an emotional level that a relationship is built

XXV. Interview with Pat Peck
Interviewee: Pat Peck
Interview conducted on: March 21, 2007
Position in organization: Orientation and Mobility Coordinator at Boronia office (RVIB)

Summary: Pat is an orientation and mobility instructor from the Boronia office. Pat works on building a trusting relationship with her clients, and works to ensure that the clients have more control over their everyday living through achieving goals. Action teams supported by Pat, and she also would like to see a list of personnel that could supplement the thin O&M staff of Vision Australia in the event of an emergency.

Question 1: In terms of Vision Australia and this Boronia office, what is the position you hold and what is it that you do?
- O&M like Plaxy
- Most clients of the organization have problems with mobility and orientation in their daily lives due to vision loss
- After a referral or the client's inquiry, general information is already known and she calls to set up initial meeting
- At meeting, directly discuss what goals client wants to achieve
- Tries to give the clients as much power as possible

Question 2: Do you always ask goals formally at the first few meetings or does it come about in a different way?
- The client generally knows what it is they want to achieve from their interactions
- She first tries to assess impact of vision loss on daily life and activities, emotional state, independence level
- Attempts to focus on setting up trusting relationship
    1. Will interact with client for hours at a time
    2. Ask them to do things that might be difficult or scary
    3. Need for there to be a level of trust
- Goals may develop from actual meeting and face to face discussion
    1. Can see client's ability when they offer tea
    2. When they move about the home
    3. Interaction with family and surroundings

Question 3: Who were you affiliated with before the VA merger?
- With RVIB only before
- Total of 7 years to date 5 with RVIB

Question 4: In terms of client outcomes and your position in specific, what would you see as a positive outcome at the end of a program?
- The client has more control over their daily life and activities
- The attitude has become positive—feel better about themselves
- Believe that they are responsible for the outcomes and that the O&M instructor only facilitated the progress
- The idea that they can achieve more and that more goals can be set
- The achieving of the original goals the clients set up
- Change in the attitudes of the family or carers
    1. Generally, can be difficult for family and they tend to be negative
    2. Want an overall change in the atmosphere to better client life
- More informed clients—explain why they can't do things or how it is possible that they can
- Give access to councilors and information for use after the end of the program so that they can continue to grow

- Generate an overall awareness
- Find the positives in life for the client—good health otherwise, good family, etc

Question 5: Does the client always dictate the direction the service is to take?
- Usually geared towards personal interactions
- The client has traditionally a main goal or something they want to work on
- As the program progresses—more goals come to mind or they become more in depth
- Referral is typically from doctor, teacher, or family—sometimes actual client

Question 6: Do you generally find that the clients prefer a more informal meeting when it comes to assessments?
- They prefer face to face interaction-staff and clients
- Learn a lot more by actually being where the client is
    1. See how they move around
    2. See how they cook
    3. Interaction with the family

Question 7: Outcomes assessments in your experiences, have you had anything besides the computer when you end a case?
- Typically add assessments of outcomes to the file notes
- "The click boxes are useless"
- Hard to make sure that what you write is accurate but also something the client can later read without being offended
- Hard to determine if a staff member thought more could be done and the client ended it or if there was a different result
- Wondered if a more precise checklist could be made and utilized by everyone

Question 8: With the upcoming implementation of the new client service model, do you have any reserves or excitements?
- Concerned about staffing levels
    1. The organization is already understaffed
    2. Management needs to make benchmarks for points at which new staff members are added so as to ease case loads
- O&M programs are hard and usually lengthy
    1. Not a lot of applicants
    2. Wants a list of "emergency O&M" personnel
    3. Wants to be able to call someone not in the field at the moment but who can work a case especially in an emergency
    4. Would take a bit of pressure from the few staff members currently

Question 9: How do you feel about the idea of a key contact person?
- Used to have that system where everyone was a service coordinator
- Fascinating in that you develop a very personal relationship and know exactly what is going on with the client
- Beneficial more to the client if the there are specialists in the area to make sure that care is the best it can be
- The current computer system can be used to determine more information if ever needed

Points of note offered by Pat:
- Wants to make sure that access to Maree is still free flowing since beneficial to staff and clients
- Important to make sure that VA continues to consult directly with clients to determine their positions
- Wants to maintain professional teams
  1. Good for bouncing ideas off concerning cases
  2. Greater services are provided

XXVI. Interview with Robyn Poynting
Interviewee: Robyn Poynting
Interview conducted on: April 16, 2007
Position in organization: Orthoptist in Lismore (RBS)

Summary: Robyn has been with the RBS organization in Lismore for 11 years. The Lismore office serves as a subsidiary of the Coffs Harbour office, so it serves a much smaller capacity than some of the others. Robyn had much to say about client outcomes in the older RBS model and generally reiterated some of the stronger points of other interviewees.

Question 1: Could you please provide some background information on your training and experience with the organization?
- 11 years with Lismore
- Part time
- Lismore a subsidiary of Coffs Harbour

Question 2: How would you define successful client outcomes?
- Not necessarily reading or directly achieving what the client wants but finding alternative ways to access information
- Meeting goals
- Low vision service questionnaire before services tells Robyn what the clients want
- 3-4 weeks later, they will follow up with a phone call to ensure the strategies and products they prescribe are being effectively used by the clients.

Question 3: Do you personally discuss outcomes with the clients? Do you know of any outcomes assessment techniques used in the past?
- There is a phone follow up at the conclusion of services
- It is conducted by the service provider and this familiarity is essential

Question 4: Do you have any suggestions on how outcomes can be evaluated when the new model is implemented?
- Currently satisfied with techniques used in Lismore
- Allows clients to assess outcomes for themselves
- Children's services ought to be followed up more closely than other services

Question 4: To what extent do you understand the new service model of VA and what are some suggestions you have about its implementation?
- Read model three months ago when it came out, no real need to read it since

- Reads usually the low vision section, which is pertinent to orthoptists
- It states the clear role of orthoptists, but not of optometrists—curious to see what that role is.

Question 5: Do you have any comments or suggestions on client intake that can allow for a smooth implementation of the new service model?
- There is currently an increase in clients but not in the hours of service, so things are getting cluttered
- Everyone there does coordinate services
- Service coordination comes with no burden and compliments her work
- Her skills may not be used to the fullest because of the time constraints of service coordination
- Training for service coordinators could be effective, or perhaps optional for those that do not feel comfortable with it. Background on service coordinators should be taken into account and has an effect on their skills coordinating services.

XXVII. Interview with Luke Price
Interviewee: Luke Price
Interview conducted on: March 29, 2007
Position in the organization: Orientation and Mobility Coordinator at Heidelberg office (RVIB)

Summary: Luke has been an O&M in the VA organization for 5 years. He received his BS in Health Sciences with a major in O&M. His first job was as an intern with the Guide Dogs Australia organization and he now works with adults and students. A positive outcome for Luke would be not just a greater mobility but also independence.

Question 1: What is your background both before and with the VA organization?
- O&M acting in the Senior roll
- 5th year with the VA organization
- Has a BS in Health Sciences with a major in O&M
- Began work as an intern with the Guide Dogs Australia organization
- Now works with adults and students

Question 2: Who were you affiliated with before VA merged into one organization?
- Only RVIB

Question 3: In your specialty, what do you consider a positive outcome?
- When the client takes control of his/her mobility and independence
- They feel that after working with an O&M that they have achieved more independence for themselves
- Give families of clients a better understanding of what mobility actually is
- Give families ideas about how to help their children become more independent

Question 4: During your time with VA and the RVIB organizations, have you ever come across assessment tools used to determine client outcomes?
- Possible for individuals who lose their vision suddenly to still be able to do things after—where O&M training comes in

- Possible that clients make goals for themselves even with Luke that they don't actually achieve but there is still positive outcomes along the way
- Does recall that clients would take survey about the O&M program specifically through the phone or interviews
- Questions included confidence about accessing certain avenues, what works in the training, what was missing that they would like to see, etc
- Questions were kept short
- Designed originally by the ex-RVIB O&M team about 8 total
- Last survey he knows about was at the end of 2005 and the beginning of 2006

Question 5: Any ideas concerning how to go about assessing client outcomes from this point and with your past experience?
- Interview clients about how easy it is to access services
- How are they able to actually get to the centers if that is where the services are
- Is public transport a possibility

Question 6: Do you have any concerns about the new client service model or anything that you are excited for?
- He likes the strong multidisciplinary teams that are found in the new model
- Believes that O&M services should be administered by trained O&M professionals and not volunteers
- Notices that there is an increase in O&M numbers in NSW where previously there had been very few
- Luke has a major concern in the areas where O&M numbers are very small—will volunteers be used to fill these gaps? Is there a more consistent effort to hire?
- Wants to know how volunteers will be trained in any capacity—fears loss of services

XXVIII.   Interview with Gwen Rees
Interviewee: Gwen Rees
Interview conducted on: March 21, 2007
Position in organization: Research personnel at CERA

Summary: Gwen Rees has a Ph.D. and is primarily concerned with research in the field of diseases and conditions affecting the eye. Recently, she and several colleagues developed over time a system for evaluation of the impact of low-vision services to individuals using a questionnaire format. The tool is named the Impact of Vision Impairment Profile or the IVI. This tool was established to be credible through a study in which clients of Vision Australia's low-vision services were asked to complete the survey post-intervention. Important things that Ms. Rees and her colleagues came across through the implementation was that personal interviews were the best method by which to conduct an evaluation assessment focused on outcomes. This setting enabled the interviewee to have questions or concerns about the actual tool answered so as to be able to give more credible answers. A phone implementation also proved useful for the same reasons. Mailings were not found to be credible for several reasons, the most obvious being the inherent problem with actually being able to read the questionnaire. Any questions the client had would also be unable to be answered and would thus lead to possible errors in the results. All of this information was then given to the top tier of Vision Australia executives for further use in the organization where appropriate.

Question 1: What do you do in terms of the association and its background?
- Centre for Eye Research Australia (CERA)
- Separate from the Eye and Ear Hospital
- Part of the University of Melbourne and predominantly research in the eye
- Conduct assessments of impact of low vision on individuals
    1. impact on daily life
    2. Mental assessments-depression?
    3. create assessment tools
    4. Devise methods to lessen impact of low vision on daily life for individuals

Question 2: How did your engagement begin with VA?
- CERA looks at the impact of VA services on new clients
- CERA specifically looks at quality of life related issues and assessments
- Have had interaction with VA and its pre-merger organizations for 10+ years
- Funding is provided to the CERA from VA and its holders
- Have previously developed appropriate assessment tools for the organization

Question 3: What tools have you developed specifically in the past?
- 2 new papers being published based on the information research has found
- New assessment tool called IVI (Impact of Vision Impairment Questionnaire)
    1. Quality of life assessment specifically for vision impaired assessments
    2. Created with VA
    3. Originally used focus groups to determine accessibility of questions and wording as well as ideas
    4. Followed up with assessments of evaluation and reliability studies
    5. Final draft (first attempt) was in 2002
        a. 32 total items falling under 5 categories of living
        b. Has undergone further reassessments in past few years
        c. Uses patient centered scale
- For vision specifics-this is the best option thus far to take into account quality of life
- Not VA specific
- Designed for any assessments taking into account low vision impact
- Does not account for blind individuals

Question 4: How has the merger of VA changed your organizations interaction? Have you needed to make a new set of assessments?
- No real noticeable change since merger
- Still based around data even if it comes from fewer places now
- Not really based on specific service provisions, just the end result

Question 5: After creating the assessment tool, how did you find it was best to implement it?
- One on one personal interviews were the best option
    1. Eliminated bias and allowed for explanation of questions
    2. Easier for clients since they have trouble seeing
- Did do some over the phone, very few sent via mail

Question 6: Why do you not recommend anything being sent through the mail?
- Impossible to eliminate bias when in the mail-helpers at the home, situation etc

- Misinterpretation of questions with no available clarification can lead to the wrong answers
- Hard to actually use

Question 7: How did you determine a representative sample when first implementing the IVI?
- Gathered data from VA in terms of demographics—age, gender-diseases etc in percentages
- Vision Impairment Project-received information on residents of Victoria to include the same demographics
- Used those as benchmarks for their data and the results of the survey to determine relevance to VA and their clients without only polling the VA clients

Question 8: Once you send out the IVI or other assessments, what do you do with the data you receive back?
- Have a research team at CERA that analyzes the data only
- Done via paper-slowly turning over to database
- Compare numbers received for a data set
- Look through files for info from VA clients-services received, length of time in program, use of OT vs O&M etc
- Add that information to what is received from IVI to make generalizations
- Statistical analysis is done again generally-no names or specifics
- Provide information to VA-how many services etc

Question 9: Who do you give the information to in the VA organization?
- Given to the top level executives—CEO and state managers
- Info is not directly given to O&M instructors etc
- Up to VA to further disperse

Question 10: When conducting these assessments and studies, do you have problems or guidelines when it comes to patient confidentiality?
- The information given is done in groupings
- No names are attached or can be traced back even on the assessments
- All findings are generalizations
- All information of CERA is in public domain as it is a research facility

Question 11: As we undergo these outcomes suggestions and implementation assessments of the service model do you have any suggestions for us?
- It has been difficult to determine from VA what services have actually been used by clients
- Nothing is done electronically-what is, is done sporadically and not effectively
- Makes it more difficult to make appropriate realizations and generalizations
- No concept of length of intensity of program in data
- Only source of info is from notes at end of cases which are also hard to decipher

Points of note offered by Gwen:
- PubMed on the web has information about the IVI
    1. Specific information about the development from the early stages
    2. Information on how the domains were chosen
    3. How the questions were organized and devised

- Questions the center has for the project
    1. How do you know if a client is impacted by the change from the pre-merger delivery model to the new model?
    2. There tends to be no information available from person to person
    3. Pre and post assessments are a good idea and even necessary to determine any progression
- Are there specific reasons why the new client service model has not been implemented yet? Any actual road blocks to look into?
- The new IVI can assess even better the impact of vision loss on individual
    1. 28 total items in 3 domains
    2. Domains are: Emotional state as a result of vision loss, ability to access pertinent information, and level of independence
- Important in any survey to include way to take into account any irrelevant questions
    1. Individuals may no longer partake in an activity for a reason other than the loss of sight. Need to know this to eliminate errors and preserve credibility

XXIX. Interview with Harry Simon
Interviewee: Harry Simon
Interview conducted on: March 29th, 2007
Position in organization: Employment Consultant at Canberra office (RBS)

Summary: Harry is a recently hired employment consultant in the Canberra office. He has had a minimal amount of client interaction and is himself legally blind. He helps retrain individuals to make them more employable. The only thing Harry wanted to point out was the need for electronic record keeping since paper documents lead to things being lost and inconsistencies across the organization.

Question 1: What does is your background with the organization?
- Joined VA on the first of February
- Has minimal amount of client interaction
- He finds and assists with employment through a Disability Employment Network Provider
- He is also legally blind and has been for the past 7 years

Question 2: What does your position fully entail?
- He attempts to lead a client from being unemployed to employable
- He retrains them when necessary
- When they do establish themselves with a job he sees the clients and works with them to make sure they remain successful
- Interactions could involve his actual presence but not always
- The government is the monitoring factor at all times

Question 3: Is there anything you think could be more effective in the new client service model or in general?
- Hopes the new client service model is more electronic
- Still too much paper work currently
- No major issues though with the new model or how things are currently running
- Worried about loss of paper documents and incomplete or inconsistencies

XXX.   Interview with Jeanette Smith
Interviewee: Jeanette Smith
Interview conducted on: April 5th, 2007
Position within organization: Occupational Therapist at Ballarat Office

Summary: Jeanette has worked with Vision Australia for over 22 years and was a VAF employee before the merger. She is an OT and handles a pretty big chunk of the state. Her idea of a client outcome is whether or not the client has achieved the goals they set out to achieve within reason. She works with clients at the start of her services to determine their goals in an informal manner. In terms of actually assessing outcomes, the feeling that an experienced OT gets from the client is what is really important in indicating a positive outcome. She is not aware of any real outcomed assessments done by Vision Australia in the past, and she worries that the role of the action teams is not well outlined and that staff don't really know what they are for in the new model. She also thinks that successful service model implementation will result in positive public relations with clients.

Question 1: What is your background? And what do you do on a daily basis?
- Has worked with vision Australia for approximately 22 years as an OT. Her background is in occupational therapy.
- Her particular office serves a sizable portion of the state, and she sees people that come to low vision clinics, and she follows up with home visits where appropriate. She also takes walk-ins.
- Her primary job is to determine the client's needs in the field of occupational therapy and to help them fulfill those needs in terms of occupational therapy.

Question 2: What is your pre-merger affiliation?
- VAF

Question 3: How would you define a successful client outcome?
- Occupational therapy deals with very specific tasks that clients want to be able to do. Sometimes, their expectations are somewhat unrealistic, but that does not mean that the outcome is negative.
- Also, the most important outcome from her perspective is that clients are given the proper service pathways to get the services they want and need.

Question 4: Do you deal with clients about their outcomes? If so, how?
- Yes. As part of client intake and the beginning of occupational therapy, clients construct a list of goals based on what is bothering them about their vision loss.
- The occupational therapist takes the things bothering the client and works with them to construct a set of goals

Question 5: Can you suggest strategies for client outcomes assessment that would be easily integrable into what you already do?
- Ideally, people love to see a form that has a bunch of positive client outcomes with all the boxes checked, but in actual practice, its just a general feeling you get from the client.

Question 6: Do you know about any specific outcomes assessments used by Vision Australia in the past?

- Not really familiar with any.
- Many years ago, there were things called multi-skilling forms that determine wether or not the staff were doing their multi-faceted jobs properly, but that is not used any longer.

Question 7: Do you have any concerns about the new client service model? What indicates successful implementation of the new service model?
- There is much concern in everyone's minds right now about the action teams.
- She would also like to see a break down of the different age groups served by VA because most of the clientele in Ballarat is elderly people that don't use the internet, so they don't get information like that. It would make it easier to see who needs to have things mailed. Out to them.
- Indicators of successful model implementation are when clients are in complete control of their lives and they tell each other about how satisfied they are.
- If high quality service is delivered, then the model is working and the public relation with the clients is good, but if the model is not doing what it is supposed to do, then the public relation with the client will falter and it will indicate that the model needs to be analyzed.

XXXI. Interview with Andrew Tester
Interviewee: Andrew Tester
Interview conducted on: April 3rd, 2007
Position in organization: Occupational Therapist at Mitcham office (VAF)

Summary: Mr. Tester has been with the organization for 12 years and has worked in many offices from the former VAF business unit. He is an occupational therapist working in the Mitcham office at the present time, and his work with outcomes assessment is personal and follows the service pathway module of the VAF service centers. He had little criticism of the new service model, however there was some concern with the key contacts and the use of volunteers as described in the service model document.

Question 1: What is your background in terms of Vision Australia and occupational therapy?
- Andrew has been with the organization for 12 years, dating back to the Association for the Blind (the pre-VAF business unit).
- Since then, he has worked in the Essendon and Box Hill offices and is currently in Mitcham.

Question 2: How would you define successful client outcomes in terms of occupational therapy? How are goals used during your service provision?
- Client outcomes are having observed a sense that the client has reestablished a level of satisfactory independence.
- Goals are generally very loose at his level. Clients do not really know what their goals are, and are directed by a staff member most of the time.

Question 3: Do you discuss outcomes with clients? Is this discussion formal and survey based or informal and discussion based?
- The format followed by the staff at the Mitcham office is the service pathway model where the goals are written down and signed off when they are completed along with any notes on the completion of the goals.

- Clients prefer an informal discussion with regards to outcomes. It provides value in that they are doing an evaluation of their progress in addition to the VA staff member. External surveys would be limiting to the feedback of the clients.

Question 4: Can you suggest strategies for assessing client outcomes that would be easily integrated into the current system?
- Current system is not perfect, but there is not much to improve
- An agreement between the client and the service provider that outcomes have been met is best.

Question 5: Do you know of any client outcomes assessment techniques used in the past—say, in the Association for the Blind model?
- Outcomes were assessed by intervention in that model. When he felt as though outcomes were met, he would end the services he provided.
- He worked with a service coordinator, who he mentioned to be a valuable resource because a service coordinator came from a different background and has a different perspective on services. This was said to be quite valuable.

Question 6: Do you have any concerns with the new client service model?
- Two things were of particular concern: volunteers and key contacts.
- When using volunteers, you must be careful to protect client confidentiality and ensure that the volunteer is not stepping outside their expertise
- The key contact resembles the old VAF model in which anyone could coordinate services. It allowed for everyone to be knowledgeable on many things but perform nothing particularly well.
- He hopes that the approach will not result in a generic staff that is all service coordinators. The focus is taken from expertise and it dilutes the services of VA while bogging down staff members with service coordination duties.
- In VAF, the aforementioned downsides were observed to an extreme. Responses to client needs and the changes in technologies were difficult to observe and adapt to when there are so many other things such as service provision to be concerned with.
- The RVIB model, in which there is one service coordinator that is not a service provider, was preferred.

XXXII. Interview with Simon Toomey
Interviewee: Simon Toomey
Interview conducted on: April 4th, 2007
Position held in organization: Regional Counselor at Ballarat office (VAF)

Summary: Simon Toomey counsels clients throughout half of region 1 at the Ballarat office. He helps clients cope with grief about their vision loss or other problems they may have as a result of vision loss. Simon has only been a counselor for 8 weeks but has worked with Vision Australia for 4 years. The first half of those 4 years was spent working under the RVIB model. Simon also held the position of senior service coordinator while at Ballarat and when he was with the RVIB, where he only coordinated services for clients entering the system. His position on outcomes is client dependent, and he believes it must remain client dependent because client needs are very dynamic. Simon also has no concerns about the new client service model and considers it well structured and well detailed. He thinks its successful implementation will be indicated by a range of different things namely; client

satisfaction, worker satisfaction and system satisfaction, that will all require different forms of measurement and analysis.

Question 1: What does your position as Regional Counselor fully entail?
- Helps clients in region 1 deal with their vision loss and any other difficulties they may have in their lives.
- Used to be a senior service coordinator, so he did a lot of client intake work and also served as a resource for other service coordinators in the area.

Question 2: Did you have a pre-merger affiliation?
- Originally worked in the RVIB model, but he has been in Ballarat for 2 years.

Question 3: How would you define a successful client outcome?
- At the Ballarat office, OT work is particularly important.
- Special emphasis is placed on computer training because many of the clients he has worked with were young people that require the use of computers for work or school.
- This training helped the clients increase their access to information and their productivity.
- Anything that allows the client to increase their enjoyment of life.

Question 4: Do you deal with clients in the context of outcomes? Is it informal discussion or more structured? Do the clients seem to prefer an informal discussion?
- He knows that RBS used to have a very structured case management system.
- There was a place in the RBS database that was reserved for clients to make comments about the service provision through the service coordinator.
- Not really structured in VAF or RVIB model, clients do seem to prefer the informal discussion, but it also depends on what they are used to.
- Sometimes clients need to be given examples of different services and what those services can offer but it is as client driven as possible.

Question 5: Can you suggest strategies for client outcomes assessment that would be easily integrable into what you already do on a daily basis?
- The models he has worked with have always been very reliant on client input, and there has always been emphasis placed on the independence of the client.
- Some surveys have been used recently, but he does not remember the specifics of it but it is still very quantitative.
- It comes down to the local offices getting to the root of how outcomes information should be collected.

Question 6: Do you know about any specific outcomes assessments used in the past by Vision Australia?
- There was a registered comment form used by the RVIB.
- Clients were given the opportunity to make comments about the way services were provided, and how they could or should be changed.
- It is not used anymore and it was not really outcomes based.

Question 7: Do you have concerns about the new service model? What do you think indicates a successful implementation of the new model?
- No concerns with the new model. Document was amazingly well detailed even

though there was a lot of jargon. He thought the new model was well structured and thought out.
- A successful implementation would be indicated by a range of things, namely, client satisfaction, worker satisfaction, systems satisfaction.

XXXIII.   Interview with Chris Waller
Interviewee: Chris Waller
Interview conducted on: April 11, 2007
Position in organization: Adaptive Technology in Newcastle (RBS)

Summary: Chris has served in adaptive technology for 8 years in the Newcastle office. He does not work directly with client outcomes, so the questions in the interview were tailored to him.

Question 1: Could you please provide some background information on your training and experience with the organization?
- 8 years with adaptive technology
- Clients are referred to him and he matches what they want to do with what is available. He provides DAISY machines, computer software, Braille magnifiers, etc.
- Provides home visits and deals with all ages

Question 2: How would you, as an AT instructor, define successful client outcomes?
- Clients are in a position to do what it is they want to do
- No goal based setup since it's entirely technology based and no skill learning at this level

Question 3: Do you personally discuss outcomes with the clients? Is it an informal setting? What do they prefer?
- Generally does not discuss with clients, works with employment consultant and trainers and they handle the skill training which would have outcomes assessment

Question 4: Could you provide suggestions on client intake and service coordination?
- No problems getting clients, since everything is internal
- Centralized intake is best
- Big complaint: clients that come straight to the service center are referred to the 1300 because they have no paperwork, but the 1300 number refers the clients back to Newcastle—serves as an endless cycle
- Only service coordinator for single-need clients, hands off multifaceted needs to more skills coordinators

XXXIV.   Interview with Ros Wellington
Interviewee: Ros Wellington
Interview conducted on: March 27th, 2007
Position held in organization: Orthoptist at Boronia office (RVIB)

Summary: Ros is an orthoptist working in the Boronia office. This is her 8th year in this discipline, and has always worked with RVIB. She finds that client outcomes can differ from client to client. She is fairly content with the new service model, as any concerns she had

were addressed by upper management after this project team inform them of the concerns of service personnel.

Question 1: How long have you been in your specialty and what specifically does an orthoptist do?
- Worked for the past 7 years (this is her 8th) in the specialty
- There are two types of orthoptists---General and Rehabilitation
  1. Ros is rehabilitation
  2. She does assessments of vision impairment
  3. Looks with the client at all available products and services
  4. Assesses all age groups from birth to the elderly
  5. One of the only positions that has such a broad client range and is very diverse

Question 2: Do your assessments take place in the home or do the clients come to the VA centers?
- Easiest to do assessments at the home and that's where majority are conducted
- More relaxed setting
- Clients are used to the surroundings
- Some clients do chose to come to the centers but home service is offered

Question 3: Before the merger, what organization(s) did you work for?
- Always worked for RVIB
- When first began working, the model had workers doing service coordination as well as their specialty
- Transitioned into one service coordinator and then only specializing
- She prefers that method

Question 4: In general terms or catered to your specialty, what would you define client outcomes as? What is a positive outcome?
- Depends on the clients—some clients have only one assessment, others have several
- In the informal setting, establish goals
  1. Can be very general and concern available low vision aides
  2. Can be for the client to be more informed about their condition or low vision in general
  3. Can be specific such as being able to read the mail by themselves
  4. All want confidence back

Question 5: In your day to day activities, and during your assessments, do you record outcomes or general progress?
- In the case notes kept on a client-there is an area called Needs
- In the Needs area, record purpose of involvement with organization, any main goals want
- At the end of the assessments and service, also follow up phone call
  1. Check whether goals were met or if there can be more done for client
  2. Basic idea of whether successful or not
- All information from phone call goes into final write-up and outcomes assessment

Question 6: Have you found that clients prefer an informal setting to a formatted questionnaire?

- Definitely especially because it's easier for them to take
- Get more information on both sides in that setting
- Can appropriately ask the questions

Question 7: The new client service model of VA, are you at all familiar with it?
- Not especially familiar with every detail
- Seems very broad—more of a framework
- Says that there will still be an orthoptist, but how many and in what capacity?

Question 8: The Key Contact concept has been discussed recently as an issue. What do you think? Any concerns?
- Went to a meeting with Graeme yesterday—specifically discussed this issue
- Graeme seemed to imply that flexibility would still be present
- Larger offices like Boronia would remain having one service coordinator as the key contact
- Small offices with fewer staff would have the dual roles

Question 9: When you spoke with Graeme, did any other issues come up?
- The issue of intake was mentioned
- The concept of the National Service Contact Center was discussed so far as how these additional clients would be handled? Did everyone still need to go through the same traditional pathways?
- She asked if home visits would still be possible on the same scale and found that at this point that was anticipated to continue.
- Graeme mentioned there being flexibility especially if a client knew exactly what he/she wanted wouldn't have to go through every specialty to receive it.

Question 10: Do you have any suggestions for us in terms of the service model or outcomes assessments?
- She feels that outcomes are done at an adequate manner now
- A written guide may be beneficial as a rubric for new staff to follow
- Service coordinator could make earlier calls as that can affect the validity of the discussed outcome if time has led to a progression of needs not there at the time of service.
- Ros calls clients 4 weeks after the final meeting
- Clarification in the client service model is needed
- Orthoptics are varied based on the pre-merger organization
- Need clarification on how skills will be used and programs that will continue

18 Appendix K

Focus Group Transcriptions
Focus group: April 2, 2007

Location: Mount Waverley Youth Center, Mount Waverley

Participants (last names withheld for purposes of anonymity): Wanda, Betty, Peter, Norma, Launa, Dorothy, Bill, Nick, Joan

The meeting began with brief introductions from Scott and Adam with a background on the project and the purpose of the focus group.

Question 1: What were the goals of the services you received from Vision Australia? Any additional background information was welcomed at this time.

- Wanda began as a school child at an RVIB school located in Burwood in 1960. She gained employment through the service of RVIB on St. Kilda Rd. She was a public speaker for RVIB and is now for VA. Although Wanda currently does not subscribe to any of Vision Australia's services, she and her husband are completely blind, and she serves as an educator for 2 client self help groups (Mount Waverley and Boronia).

- Betty is 83 years old and for a long time worked as a freelance journalist that enjoyed a great deal of success in her work. She realized that she lost the last bit of her vision at a train station one day and then drove home. She was never able to drive again. She was diagnosed with detached retinas, and referred to RVIB. She entered through the technology department and used adaptive technology to operate her computer and continue writing her columns. She continues to use the adaptive technology of Vision Australia, and as a result feels as though she has her life back. Betty writes a weekly column called The White Cane, which provides information and support for the blind and visually impaired. Betty also noted that Vision Australia does not provide much support in terms of recreational activities in comparison to the pre-merger organizations. Many recreational organizations (i.e. the blind sports association) are managed entirely by visually impaired individuals, and support from Vision Australia would be advantageous. Betty also mentioned that VAF was extremely helpful in periodically contacting and updating her with information that she could add to her

column, a personal client interaction that she would love to experience with the new VA organization.

- Peter is 87 years old and is currently retired. He was diagnosed with macular degeneration. He received services for about 5 to 6 years in Kooyong and he occasionally returns to Kooyong to make cane baskets for individuals that use canes. Peter expressed a great deal of thanks for the assistance of Vision Australia's services. He relied, and still relies, heavily on the daily living and OT skills that are provided by Vision Australia. According to Peter, he would not have learned how to cope if it were not for the care of Vision Australia.

- Norma was diagnosed with retinal pigmentosa and began receiving services from RVIB at the age of 53. She currently enjoys the self help groups and swimming lessons with a local group that have been provided by the RVIB. Norma, along with Betty, Peter, Laura, Dorothy, and Nick, owns a DAISY (Digital Audio Information SYstem) machine that allows her to listen to audio books. These "talking books" taught Norma how to use her cane in addition to several key life skills. Norma tends to become disoriented when traveling thus the services of Vision Australia were essential in her mobility throughout her home, especially when navigating up stairs and from entering and exiting her home.

- Launa's service provision under the Kooyong office has taken place for 16 years. One Monday afternoon, she realized that she lost her vision very suddenly and could not read the newspaper. She could not drive effectively either. She was diagnosed with macular degeneration. She really enjoys the support groups established by Vision Australia, as she has met many friends and has developed dinner groups as a result of the friendships she has established there. She loves books, and was extremely grateful for the DAISY machine that she owns and spoke nothing but praise for the depth and quality of the library at Kooyong. Launa noted that the library has lost some appeal lately because not only does the library now require appointments (which serve as an inconvenience for clients that just want to read), the staff were not regarding as being very personable.

- Dorothy was celebrating her 97th birthday on the day of this focus group. She has had macular degeneration for 18 years and has attended clinics at Kooyong for 12 years. She periodically goes to day centers and special interest groups, and that is really the extent to which Vision Australia assists her at this juncture. Dorothy expressed concern in the fact that many trips that she used to enjoy under the pre-merger organizations no longer exist. Dorothy and Betty have traveled to the Colorado Rockies and to Fiji and they hope that Vision Australia can restart this program so that others can have the same opportunity. Since these trips have been canceled, Dorothy had no one to go on holiday with.

- Bill mentioned that he was a former interior designer, but provided little insight as to his service provision under Vision Australia. He did mention that continuity was a big issue and that the VAF offices made a very abrupt and sudden change to Vision Australia. Bill is also this groups representation on the regional client committee.

- Nick is 83 years old, and was also diagnosed with macular degeneration. Nick noted that he was formerly a mechanical engineer. He received ophthalmologist services because he had difficulty driving and reading. He was referred by his ophthalmologist to Vision Australia and has only seen the unified VA model since he is new to the system. He found the library to be very useful and he also bought a CCTV which was quite helpful. In addition, he received services from an orthoptist, who referred him to quality of living training. Nick is a widower who lives alone at home and does as much as he can around the house. He has gained a great deal of confidence and independence and has no real criticisms of VA, which he found very helpful. He was very glad the information flows through local client groups and that trained professionals discuss everyday solutions with clients. He wanted to thank VA for allowing him to maintain his mobility.

- The group agreed that the services sought through VA were an effort to retain independence and basically to enjoy the facets of life that are important to them. As indicated in the responses above, the second and third questions that were prepared for this focus group (pertaining to the attainment of goals and the effects on their lives)

were answered in most members of the group. For time purposes, these questions were omitted.

- Wanda went on to say that O&M, OT, and orthoptists were extremely important. Also, knowledge is key. She would like to see the clients stay updated and keep the services and their access flexible to the changing needs of clients. Wanda echoed the requests of Betty and Dorothy for more recreational activities, as these people are having to seek them elsewhere at both their expense and inconvenience.

Question 4: What is the best way for Vision Australia to get feedback from you?
- Bill noted that communication has been severely decreased since the merger.

- Wanda mentioned that meetings would be good on a larger scale that are accessible for the clients. Also, that more groups should speak to their local managers to express concerns and to also understand the changes in the organization.

- Joan introduced herself at this time. She is a volunteer for Vision Australia that facilitated some day trips through VA and other disability-related organizations.

- Many members of the group explained that service coordinators did contact them prior to the provision of services.

- When asked if a quality of life survey would be an acceptable means of outcomes assessment the group had no qualms about participating in such a research. Wanda requested that these kinds of outcomes assessments be conducted either through the phone or, if need be, in Braille, a request that was commended by a few of the other members of the group. Many people emphasized their interest in phone-based outcomes assessments.

- Lastly, a few members of the group enjoyed the approach of VA that relies on the client calling the service centers if they have goals they want to achieve. This instills a sense of independence and while some found it challenging at first, it has made a difference. They also stressed the importance of being connected with the right people

to help when they do call VA (this is being resolved through the National Contact Center and the directory of products and services which is currently under construction).

19 Appendix L

Questionnaires from RBS model for outcomes

I. *Adult Questionnaire*

Please consider how your vision impairment affects the different areas of your day to day life. These areas are listed below.

1.   **Visual Activities:**   (eg. reading personal mail, bills, newspapers, books; writing phone numbers, shopping lists, cards, letters or notes; filling out cheques, forms; seeing TV; seeing signs, train indicator boards; problems with lighting or glare; problems seeing at night or in the dark; etc).

Please list below any visual activities that you are wanting to do but are unable to manage because of your vision impairment.

2.   **Daily Living Skills**: (eg. preparing food; seeing stove/ microwave dials; dialling the telephone; pouring drinks; locating power points/keyholes; operating appliances, remote controls; seeing your watch, clock; using a computer; home maintenance; etc).

Please list below any daily living skills that you are wanting to do but are unable to manage because of your vision impairment.

3.   **Independence in the Community:** (eg. shopping; banking; identifying money; using public transport; crossing roads; negotiating stairs, gutter; etc).

Please list below any activities in the community that you are wanting to do but are unable to manage because of your vision impairment.

4.   **Personal care:** (eg. identifying clothing; shaving; putting on make-up; cutting nails; managing medication; etc).

Please list below any personal care activities that you are wanting to do yourself but are unable to manage because of your vision impairment.

5.   **Emotional needs related to your vision impairment**: (eg adjusting to the changes you are experiencing; managing the changes in roles/relationships with family/friends due to your vision impairment; difficulties planning for the future due to your vision loss; concerns about visual hallucinations; etc).

Please list below any emotional needs related to your vision impairment that you are wanting to discuss.

6.   **Social/Recreation:** (eg. craft work; hobbies; sports; social groups; etc).

Please list below any social/recreational activities that you have stopped doing because of your vision impairment and are wanting to be able to perform again.

Also indicate if you are wanting to find out suggestions/ options for social and/or recreational activities.

7.   **Educational:** (eg. advice about how your vision impairment may or may not impact on your choice of study and education; information about options for support in the education system;

Please list below the type of educational information or assistance that you need.

8.   **Employment:**

Royal Blind Society provides specialist employment assistance to people with low vision. We can help if you are having difficulties in finding employment, keeping your present job, considering a career change, or getting a promotion. This includes financial assistance with purchasing adaptive equipment you may need in the workplace.

Would you like further information on Royal Blind Society's employment service?

Please list below any areas of assistance with employment that you may need.

9.   **Information:** (eg. information about your vision impairment, community facilities and resources; benefits and entitlements, etc).

Please list below the type of information that you are wanting.

10.   **Other:**
Do you have any other concerns that haven't been covered in this questionnaire? Please list below.

11.   **General Health:**
Are there any other health problems you have that you would like us to know about? Please list below.

12.   **Support Networks:**
Do you currently receive any support from community services, neighbours, family members etc? Please list below.

If someone other than the client completed this form, please fill in your name, your relationship to the client, and the date that the questionnaire was completed.

Name:

Relationship: Date:

Thank you for taking the time to complete this form.

II. *Questionnaire for School Aged Children*
Please read this questionnaire and document your child=s specific needs in the space provided.

Visual Skills (e.g. difficulty with: reading textbooks, novels, magazines; losing place while reading; keeping writing on the lines; reading own hand writing; reading the blackboard/whiteboard/overhead projector; seeing calculator display; seeing computer screen and/or the keyboard; seeing TV; distinguishing between colours; reading signs on streets/shops/train stations; sensitivity to glare; seeing at night and/or in the dark; using low vision aids etc.).

Please list below any visual skills that your child is unable to perform and that you are wanting your child to manage more easily.

Daily Living Skills (e.g. difficulty with: eating meals and/or using eating utensils; preparing food, making sandwiches, pouring drinks; using appliances; washing up; making his/her bed; dialling the telephone; applying toothpaste to brush; identifying clothing; tying shoelaces; identifying money etc.).

Please list below any daily living skills that your child is unable to perform and that you are wanting your child to manage more easily.**Social and Emotional** (e.g. strategies to help your child make and maintain friendships; ideas for managing teasing and/or bullying; assisting your child to feel comfortable about speaking up for himself/herself with friends/students/ teachers/other adults; ideas for improving your child=s self-esteem; strategies for managing your child=s behaviour problems; opportunity to discuss any concerns about your child's vision impairment and its impact on yourselves or your family etc.).

Please list below any social and/or emotional needs related to your child=s vision impairment that you or your child would like to discuss further.

Orientation and Mobility (e.g. difficulty with negotiating stairs, gutters, uneven surfaces; bumping into and/or tripping over obstacles; moving around in dim light and/or in the dark; crossing roads independently; travelling to and from school and/or other locations independently etc.).

Please list below any orientation and mobility skills that your child is unable to perform and that your are wanting your child to manage more easily.

Educational/Vocational (e.g. concern regarding impact of your child=s vision impairment on specific subjects; information about options for support in the education/school systems; information about options for work experience or job choice; assistance with finding employment; information about financial assistance including wage subsidy and purchasing adaptive equipment for use in the workplace; information on Royal Blind Society=s Employment Service and/or other employment services etc.)

Please list below any educational and/or vocational needs related to your child=s vision impairment that you or your child would like to discuss further.

Recreation (e.g. participating in sport and leisure activities enjoyed by other students or siblings; information on social/recreational options; ideas for adapting/modifying an activity that your child enjoys; information about specific sports for people with a vision impairment; opportunities for social and recreational activities with other students who have a vision impairment etc.)

Please list below any recreational needs that you or your child would like to discuss further.

Information (e.g. information about your child's vision impairment, any benefits and entitlements relating to your child's vision impairment, other agencies/services which may be able to help etc.).

Please list below the type of information that you or your child are wanting.

Other

Are there any other concerns that you or your child would like to raise which haven't been covered? Please specify below.

School/Funding Information

Name and address of the school your child attends:

School type:
9   Government School
9   Catholic School
9   Independent School

Class type:
9   Mainstream
9   Special Class
9   Special School

School year (e.g. year 2, year 10 etc.):

Does your child have an itinerant teacher for vision? If yes, please provide the itinerant teacher=s full name:

Doctor who diagnosed your child=s vision impairment:

Type of doctor (e.g. ophthalmologist, pediatrician etc.):

Please document below the name of the person/s who completed this form, their relationship to the child, and the date that the form was completed.

Name:

Relationship: Date:

Thank you for taking the time to complete this form.

20 Glossary

Adaptive Technology Personnel:

A person holding this position within the Vision Australia organization is responsible for the supplying of current technology. The particular items given to a client are dependent upon what he or she wants to gain. For example, a DAISY player is distributed to individuals who wish to have an easy CD player. The DAISY player is designed to be easily handled by individuals with low vision or who are blind and will play music CDs as well as CD books. The Adaptive Technology individual is also responsible for supplying enough information to the client pertaining to the technology as well as providing answers if they client calls the organization.

Early Childhood Educator (ECE):

A person holding this position within the Vision Australia organization is responsible for helping clients suspected of or diagnosed with vision impairment under the age of 12. Within this delineation, there are typically further segregations. Some staff in this area only work with children from 0-6 years while the other staff work with children 6+ years of age allowing for further specialization of services and products.

The main focus of this position, regardless of the age grouping, is establishing useful goals for the child having the disability as well as teaching the family about the condition causing the vision impairment. These facets of the job are in addition to providing services and products necessary to achieve the goals set forth. An Early Childhood Educator may establish with the family of a 3 year old having low vision a broad goal of the child being able to enter kinder. To accomplish this goal, the Early Childhood Educator would work with the family and/or carers to establish smaller goals such as coping in public without being fearful. This particular position has only been found in the pre-merger RVIB.

Orientation and Mobility Coordinator (O&M):

A person holding this position within the Vision Australia organization is responsible for helping clients when it comes to mobility or orientation concerns. For example, if a client wants to be able to walk across a local street in his/her neighborhood or to be able to get to local shops, the O&M would help him/her determine his/her orientation and how to find it once outside the home. O&M personnel also help train an individual client in the use of tools like canes or talking compasses to aid in accomplishing the goals the client sets forth.

Occupational Therapist (OT):

A person holding this position within the Vision Australia organization is responsible for assisting clients perform daily activities traditionally within the home. OT's will visit a client at his/her home to determine what areas of daily life the individual has difficulties with. Anything from using the telephone, using the television, or cooking a meal can be difficult for someone having low-vision or blindness. The OT will assess the level of difficulty the individual has in the daily activities and then provide orientation services or products to help them become more independent in those activities.

An OT will also pick up any tasks a client wants to accomplish that do not fall under the O&M or orthoptist plans of service. This makes the OT a very large role with very few set plans. Direction becomes more based on the individual and what he/she wants to accomplish from the interaction.

Service Coordinator:

In the pre-merger RVIB service delivery model, the service coordinator served as the first point of contact into the organization to any new referrals. At the point of contact, the service coordinator would set up a time to meet with the new client at which time there would also be a discussion about what goals the client wanted to achieve through the interaction with VA. Using those goals, the service coordinator would try to create a plan for the client and include specific specialties like the O&M or OT.

In the new VA model and the pre-merger VAF, the service coordinator mirrors the idea of the key contact discussed in the client service delivery model of the organization.

Team Leader:

In the ex-VAF organization, recently, one manager was put in charge of two offices. When the manager was at the second office, there still was a need for guidance and order in the first office. A team leader was thus appointed as a stand in for the manager during times when the manager was at the second site. The responsibilities of the team leader are much like that of a traditional manager and in place to maintain order within the office. After the merger of the VA organization, this position was no longer needed since one manager would be in place at each office instead of having one manager with dual responsibilities.

Welfare agent:

A person holding this position within the ex-VAF organization is responsible for the initial informational interview between the organization and the client. A welfare specialist will travel to the new client's home and discuss all available options in terms of products and

services through the organization. They will also then refer the client to appropriate specialists like OTs or O&Ms based on what the initial conversation led to in terms of concerns or goals. The Welfare specialist will also direct a client towards resources outside the organization like a blind pension or a taxi pass.